



Investing In Health

*A Summary of Legislation from 2015-2022
Related to Improving the Mountain State's
Health Care Systems*

2022

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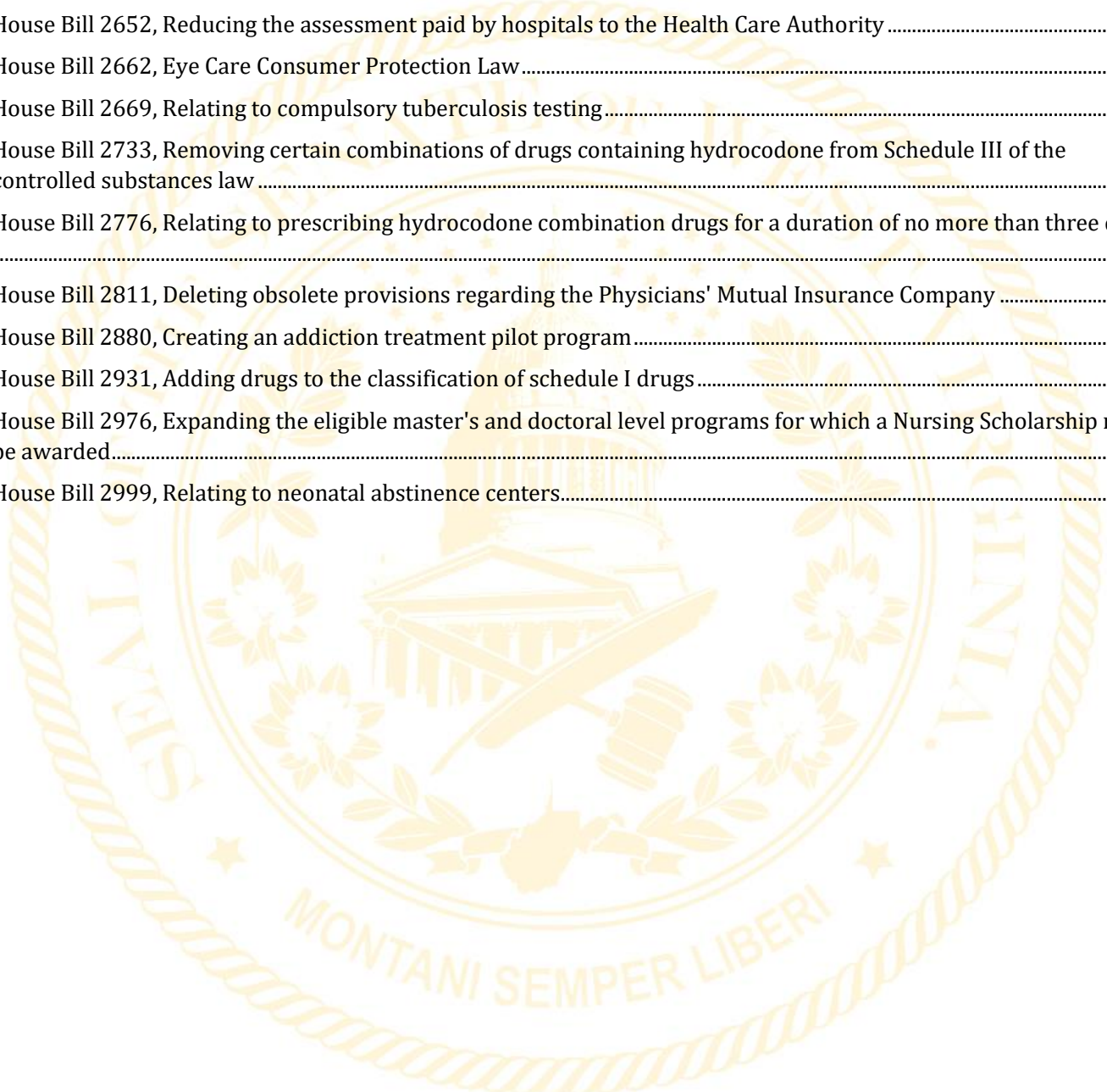
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Notes About This Publication

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2022 Regular Session



Senate Bill 25

Updating provisions of Medical Professional Liability Act

Senate Bill 25 addresses prerequisites for filing a lawsuit against a health care provider under the Medical Professional Liability Act.

In §55-7B-2(h), the bill adds “injury” as a defined term synonymous with the existing term “medical injury”.

In §55-7B-4, the bill includes references to the term “medical injury” and clarifies time limitations for bringing a cause of action under the statute. The bill adds a statement of legislative intent to subsection (b) confirming the applicability of the one-year limitations period for a cause of action for medical injury resulting in injury or death to a person alleging medical professional liability against a nursing home, assisted living facility, related entities or employees, or a distinct part of an acute care hospital providing intermediate or skilled nursing care or its employees.

In §55-7B-4(e), the bill shortens the time period in which a claimant must furnish the health care provider with a statement of intent to provide a screening certificate of merit from 180 days to 120 days of the date the provider receives the notice of claim with respect to this same category of actions. In subsection (i)(2), the bill also shortens the tolling period for any statute of limitations applicable to a cause of action against a provider upon whom notice was service for alleged malpractice from 180 days to 120 days.

CODE REFERENCE: West Virginia Code §55-7B-2, §55-7B-4, and §55-7B-6 – amended

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: June 8, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 138

Relating to Board of Medicine composition

The purpose of this bill is to remove one member from the board of medicine. This removal results in the removal of one podiatrist.

CODE REFERENCE: West Virginia Code §30-3-5 – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

Senate Bill 181

Creating Core Behavioral Health Crisis Services System

This bill requires the Secretary of DHHR to designate a crisis hotline or centers to provide crisis intervention services and crisis care coordination to individuals accessing the 988-suicide prevention and behavioral health crisis hotline from any jurisdiction in the state 24 hours a day, 7 days a week. The centers shall have an active agreement with the National Suicide Prevention Lifeline (NSPL) and meet their requirements and best standards. The center shall utilize chat and text that is interoperable and across crisis and emergency response systems used throughout the state.

The center shall coordinate access to crisis receiving and stabilization for individuals accessing the 988-suicide prevention and behavioral health crisis hotline through appropriate sharing and provide follow up services. Designated hotline centers shall meet the requirements set forth by the NSPL for serving high risk and specialized populations as identified by the Substance Abuse and Mental Health Services Administration, including training requirements and policies for transferring such callers to appropriate specialized center or subnetworks within or external to the NSPL network.

Crisis receiving and stabilization services as related to the call shall be reimbursed by the department if the individual for whom services were provided meets the definition of an uninsured person or if the crisis stabilization service is not a covered service by the individual's health insurance. The Bureau of Medical Services shall work with the entity responsible for appropriate coding and paying for crisis management services.

The bill gives the Secretary of DHHR discretion to hire employees, fix compensation, define duties and grant authority to carry out the purposes of the article. There is legislative rulemaking and emergency rulemaking authority for the Secretary of DHHR. There is an annual report requirement.

CODE REFERENCE: West Virginia Code §16-42-1 through §16-42-9 – new

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: March 8, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 213

Establishing licensed professional counseling compact

The bill creates an interstate compact for licensed professional counselors. The language of the bill is boilerplate language developed by the Counseling Compact. Once 10 states have authorized the compact, it authorizes both telehealth and in-person practice across state lines in counseling compact states. Counseling compact states communicate and exchange information including verification of licensure and disciplinary sanctions. Counseling compact states retain the ability to regulate practice in their states.

CODE REFERENCE: West Virginia Code §30-31A-1 through §30-31A-15 – new

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: June 6, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 221

Establishing occupational therapy compact

The bill creates an interstate compact for occupational therapists. The language of the bill is boilerplate language developed by the Occupational Therapy Licensure Compact. Under the compact, occupational therapists and occupational therapy assistants who are licensed in good standing in a compact member state may practice in other compact member states via a compact privilege which is equivalent to licensure.

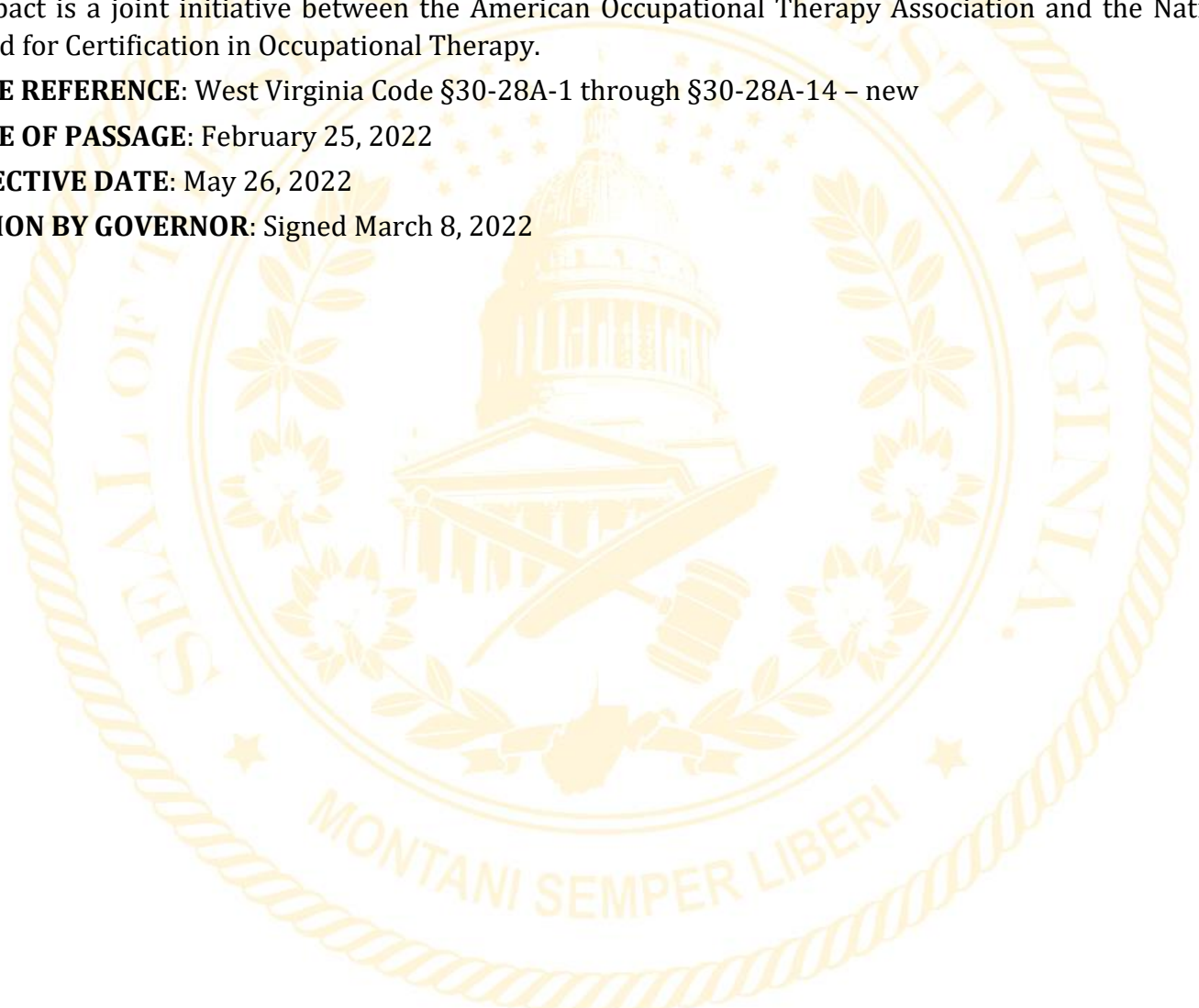
The compact establishes a licensure data system for instant verification of licensure information. It establishes a compact commission, comprised of member state officials to carry out the compact purposes. The compact will take effect once enacted by 10 states. The OT Compact Commission will then convene to establish rules and implement the data system in order to begin issuing the compact privileges. This compact is a joint initiative between the American Occupational Therapy Association and the National Board for Certification in Occupational Therapy.

CODE REFERENCE: West Virginia Code §30-28A-1 through §30-28A-14 – new

DATE OF PASSAGE: February 25, 2022

EFFECTIVE DATE: May 26, 2022

ACTION BY GOVERNOR: Signed March 8, 2022



Senate Bill 247

Relating to certified community behavioral health clinics

The bill requires the Bureau for Medical Services (BMS) to develop, seek approval of, and implement a Medicaid state plan amendment to effectuate a system of certified community behavioral health clinics (CCBHCs).

The bill provides that BMS, in conjunction with the DHHR's Bureau for Behavioral Health shall establish a state certification system for CCBHC's in accordance with the following requirements:

- The CCBHC system shall be consistent with Section 223 of the Protecting Access to Medicare Act of 2014 PAMA, as amended
- Standards and methodologies for a prospective payment system shall be established to reimburse each CCBHC under the state Medicaid program on a predetermined, fixed amount per day for covered services rendered to each covered Medicaid beneficiary.
- A quality incentive payment system shall be established for those CCBHC's which achieve specific thresholds on performance metrics identified by BMS. Such quality income payments shall be in addition to the bundled prospective daily rate.
- The prospective payment rate for each CCBHC shall be adjusted tri-annually by the Medicare economic Index. Additionally, the rate shall allow for modifications based upon a change in scope for individual CCBHC. Rate adjustments can be upon request of the provider.
- Criteria shall be established to certify a facility as a CCBHC which at a minimum shall require each directly, or indirectly through referral relationships the following services:
 - Crisis mental health services, including 24, hour mobile crisis teams, emergency crisis intervention services and crisis stabilization;
 - Screening, assessment, and diagnosis, including risk assessment;
 - Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
 - Outpatient clinic primary care screening and monitoring of key health indicators and health risk
 - Targeted case management;
 - Peer support and counselor services
 - Family support services; and
 - Community-based mental health services, including mental health services for members of the armed forces and veterans

All non-profit comprehensive community mental health centers and comprehensive intellectual disability facilities shall be eligible to apply for certification.

The certification is strictly voluntary.

CODE REFERENCE: West Virginia Code §9-5-29 – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

Senate Bill 274

Requiring secretary of DHHR to allocate CPS workers by Bureau of Social Services' district annually

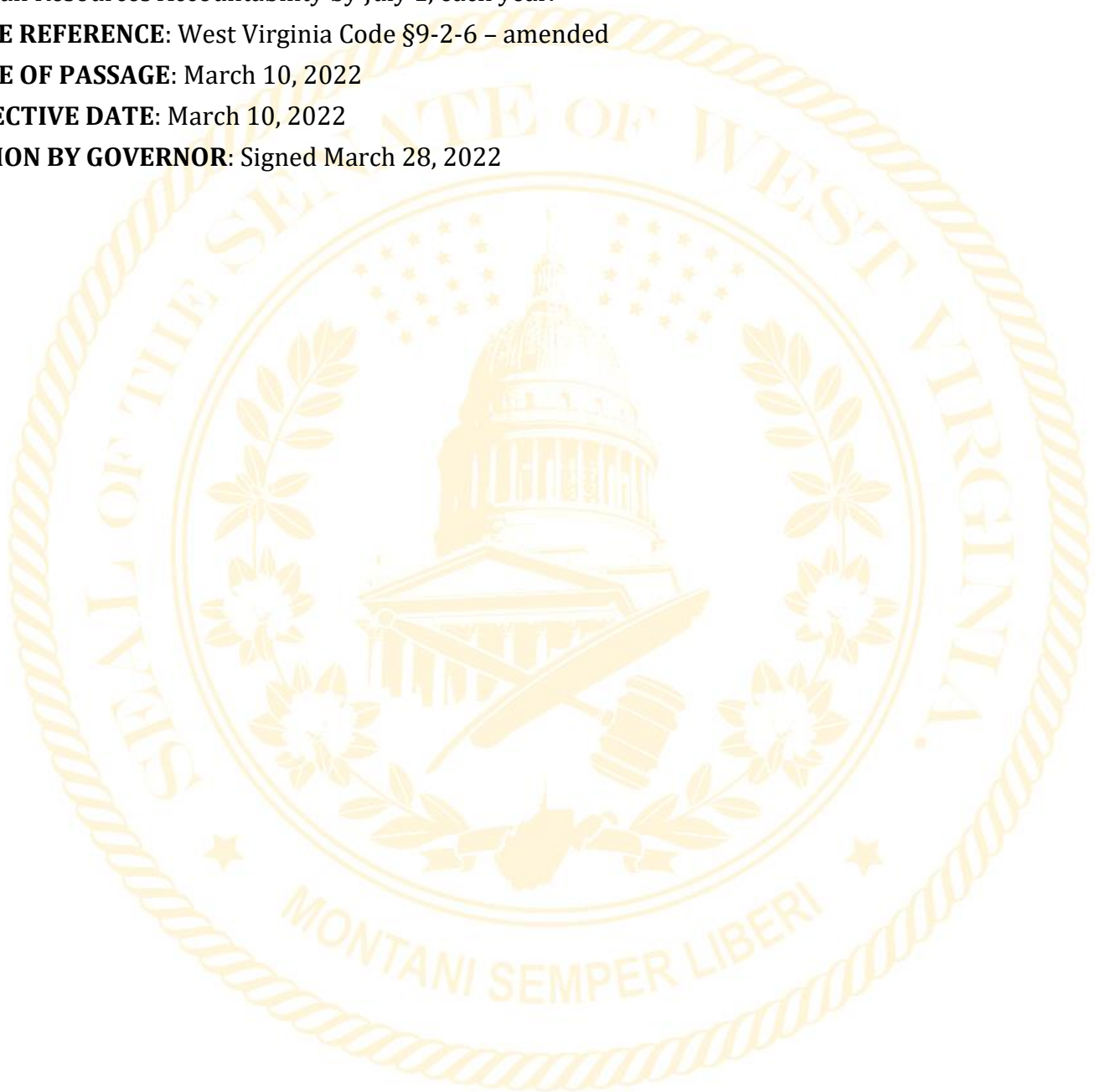
The bill requires DHHR secretary to annually report allotted CPS workers by Bureau for Social Services' district and annually report the allocation process to Legislative Oversight Commission on Health and Human Resources Accountability by July 1, each year.

CODE REFERENCE: West Virginia Code §9-2-6 – amended

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: March 10, 2022

ACTION BY GOVERNOR: Signed March 28, 2022



Senate Bill 334

Authorizing miscellaneous agencies and boards to promulgate rules

The strike and insert amendment for the committee substitute for Senate Bill 334 contains 75 rules and is known as bundle 9, the miscellaneous bundle. Only the legislative rules directly relating to the health care industry are included in this summary.

West Virginia Board of Chiropractic Examiners – Chiropractic Telehealth Practice, 4 CSR 09

The rule is new. It applies to chiropractors licensed to practice in other jurisdictions who seek to provide limited interstate telehealth services in West Virginia.

The rule provides definitions for the terms Board, Health care practitioner, interstate telehealth, registration, and telehealth services.

The rule requires an applicant to submit registration on a board approved form, pay the appropriate fee, hold licenses in good standing in all states and not be or subject to an administrative complaint.

The rule provides that the registration expires on June 30th. It references the standard of care for licensure and incorporates the same. It states that registration does not authorize a physical office. A health care professional must notify the board of any restrictions immediately. Failure to comply with the rule is grounds for disciplinary action.

West Virginia Board of Examiners in Counseling – Licensing Rule, 27 CSR 01

The rule amends a current legislative rule. It has been amended to: allow payment of application fees by credit card; remove reference to similar degrees containing the word counseling as being an acceptable degree for licensure; and add a new section 17 relating to inactive status. Section 17 sets forth the documents which a licensee must submit to the Board when applying for inactive status, prohibits a licensee with an inactive license from practicing, exempts the licensee from the need for continuing education requirements, and requires 35 hours of continuing education in the two years preceding the licensee's application to return to active status.

West Virginia Board of Examiners in Counseling – Licensed Professional Counselors Fees Rule, 27 CSR 02

The rule amends a current legislative rule. It deletes the fees for a name change or duplicate license. It adds an Inactive Status application fee of \$50 and an Inactive Status renewal fee of \$25.

West Virginia Board of Examiners in Counseling – Marriage and Family Therapist Licensing Rule, 27 CSR 08

The rule amends a current legislative rule. It has been amended to allow payment of application fees by credit card and to add a new Section 16 relating to inactive status. Section 16 sets forth the documents which a licensee must submit to the Board when applying for inactive status, prohibits a licensee with an inactive license from practicing, exempts the licensee from the need for continuing education requirements, and requires 35 hours of continuing education in the 2 years preceding the licensee's application to return to active status.

West Virginia Board of Examiners in Counseling – Marriage and Family Therapist Fee Rule, 27 CSR 09

The rule amends a current legislative rule. It adds an Inactive Status application fee of \$50 and an Inactive Status renewal fee of \$25.

West Virginia Board of Dentistry – Rule for the West Virginia Board of Dentistry, 5 CSR 01

The rule amends a current legislative rule. The amendments allow the Board to issue a teaching permit to a person who is not licensed in this state who is a participant in a dental residency program located in this state.

The rule allows the Board to issue a dental intern permit, dental resident permit, or teaching permit to a foreign trained dentist who has been offered a position in an approved dental program in this state. It also allows the Board to issue a dental license to an applicant trained in a foreign dental school who possesses a certification of a two year or more advanced general dentistry program from a U.S. or Canadian dental school accredited by the Commission on Dental Accreditation. Finally, it allows the Board to issue a dental license to an applicant trained in a foreign dental school who possesses a certification of a two year or more dental specialty advanced education training program from a dental school accredited by the Commission on Dental Accreditation. The applicant must apply for a general and specialty license and may only practice in the specialty in which he or she is licensed.

Language has been added to provide that the Board may revoke any permit for cause and that any permit expires at the end of one year or the date the teaching appointment ends, whichever comes first.

West Virginia Board of Dentistry – Formation and Approval of Professional Limited Liability Companies, 5 CSR 02

The rule amends a current legislative rule. It requires the Board to notify the Secretary of State when a professional limited liability company's certificate of authorization is no longer valid due to noncompliance or expiration of the certificate. It provides for reinstatement of a certificate that has been expired for more than 60 days or where the PLLC was in noncompliance. Finally, it states that the Board may file a complaint or take disciplinary action against a PLLC that does not comply with the law or the rule.

West Virginia Board of Dentistry – Formation and Approval of Dental Corporation and Dental Practice Ownership, 5 CSR 06

The rule amends a current legislative rule. It has been amended to require the Board to notify the Secretary of State when a dental corporation's certificate of authorization is no longer valid due to noncompliance or expiration of the certificate. It provides for reinstatement of a certificate that has been expired for more than 60 days or where the dental corporation was in noncompliance. Finally, it states that the Board may file a complaint or take disciplinary action against a dental corporation that does not comply with the law or the rule.

West Virginia Board of Dentistry Continuing Education Requirements, 5 CSR 11

The rule amends a current legislative rule. It provides that the Board may allow a licensee who does not provide proof of completion of the required continuing education to make up for the deficiency and allows the Board to assess a late fee.

A new Section 5 relates to continuing education requirements for a tele-dentistry registrant. It requires a dentist to complete the continuing education required by the state he or she is licensed in as well as three hours on drug diversion every two years. It requires a dental hygienist to complete the continuing education required by the state he or she is licensed in. The Board may randomly audit the continuing education records. A false statement on a renewal form or continuing education form is unprofessional conduct and subject the registrant to disciplinary action.

West Virginia Board of Dentistry – Administration of Anesthesia by Dentists, 5 CSR 12

The rule amends a current legislative rule. It requires a dentist applying for the permit to consent to an initial inspection of his or her facility, as well as re-inspections and requires the annual renewal of permits.

A new Section 8 relating to inspection and evaluation failures requires the Board to notify a dentist if his or her facility fails the initial or a subsequent inspection. After 30 days from receipt of the notice, the dentist may request a new inspection or a reevaluation. If the Board grants the request, the new inspection or reevaluation must be scheduled within 90 days of receipt of the request and completed within 150 days of receipt of the request. A second failure results in the dentist's loss of the ability to administer any level of sedation requiring a permit for one year. The Board may recommend the dentist receive remedial training or complete continuing education prior to any future inspections or reevaluations. Finally, the Board has the authority to issue cease and desist orders.

West Virginia Board of Dentistry – Expanded Duties of Dental Hygienists and Dental Assistants, 5 CSR 13

The rule amends a current legislative rule. Section 4 relating to the expanded duties of dental assistants was amended to state that all duties requiring a board-approved course and examination require a certificate issued by the Board to perform those duties. The dental assistant must apply to the Board for the certificate and pay the required fee.

Section 5 related to expanded duties of dental hygienists has been amended to allow a hygienist to use a laser with a wavelength of no more than 1064 nanometers for certain specified procedures. Language that was added requires the hygienist to apply for a certificate to use a laser as well as for the administration of infiltration and block anesthesia and to pay the required fee. The amendments prohibit any person from using lasers under general supervision or a public health practice permit.

West Virginia Board of Dentistry – Tele-dentistry, 5 CSR 16

This is a new rule. The rule does the following: defines terms; sets forth registration requirements, provides for annual renewal and provides for reinstatement of an expired license; requires a dentist or dental hygienist to be licensed in this state; requires a bona fide practitioner-patient relationship between the dentist and the patient and sets forth the requirements for the existence of that relationship; requires a dentist to have written or electronic protocols and specifies what those protocols must include; sets forth information which the dentist or dental hygienist must obtain from the patient or provide to the patient; requires the dentist or dental hygienist to obtain the patient's informed consent for the tele-dentistry and specifies requirements for the informed consent; requires that the dentist or dental hygienist to ensure that any electronic or digital communication is secure to maintain patient confidentiality; requires the dentist or dental hygienist to maintain a patient dental record and specifies the contents of that record; prohibits a dentist from prescribing Schedule II drugs through tele-dentistry; and sets forth prohibitions.

West Virginia Massage Therapy Licensure Board - General Provisions, 194 CSR 01

The rule sets a 10-year sunset date. The current rule requires a client to provide voluntary consent prior to a breast massage. The rule requires the client to provide a written medical directive to the massage therapist before the massage is performed. The massage therapist is required to place the directive in the client file and must also obtain written consent from the client prior to performing the massage. The massage is to be performed in accordance with the medical directive.

West Virginia Board of Medicine – Licensing and Disciplinary Procedures: Physicians, Podiatric Physicians and Surgeons, 11 CSR 01A

The rule amends a current legislative rule relating to licensure requirements and application requirements for allopathic physicians and podiatric physicians by the WV Board of Medicine.

The rule incorporates new definitions for licensee, practice credential or credential, and website. It updates the current rule in accordance with Senate Bill 372, which passed during 2021 Regular Legislative Session for approved types of postgraduate clinical training for graduates of medical schools located in Canada, the United States and Puerto Rico and for graduates of international medical schools.

The eliminates a reference to a discontinued portion of the United States Medical Licensing Examination SMLE licensing examination and incorporates new tests attempt limits imposed by the USMLE Composite Committee, the examination body for physicians. This eliminates the discrepancy between the Board's rule and the forthcoming four attempt limit set by the administering body.

Section 9 brings the rule into alignment with Senate Bill 372 with respect to temporary licensure, which clarifies that a temporary permit includes full prescriptive authority.

Section 11 includes modifications which clarify that the confidentiality provisions of the complaint and investigation process apply to all credential holders who are authorized to practice by the Board.

Section 12 includes modifications which clarify that the grounds for discipline and the types of disciplinary actions the Board may impose apply to all practitioners authorized by the Board. It provides that it is professional misconduct for a practitioner not only to exercise influence within the provider-patient relationship for purpose of engaging a patient in sexual activity, but that it is also professional misconduct to engage in sexual activity with a patient, or to sexually harass or exploit a patient. This section also allows the Board to require a practitioner to participate in a Board designated physician health program for drug or alcohol abuse as a condition of probation.

Section 13 adds that insurers shall report to the board whether credential holders also have professional liability insurance, not just licensees.

West Virginia Board of Medicine – Licensure, Practice Requirements, Disciplinary and Complaint Procedures, Continuing Education, Physicians, 11 CSR 01B

The rule amends a current legislative rule relating to physician assistants and to their licensing, practice, complaint procedures and professional discipline, and continuing education. During the 2021 session, the Legislature enacted Senate Bill 714 which updated the Physician Assistants Practice Act.

The rule provides a regulatory framework for the licensure, regulation, and discipline of physician assistants practicing in West Virginia who are licensed by the WVBOM. It include qualifications for licensure as a physician assistant; requirements for licensure, renewal, reinstatement and reactivation of expired licenses; requirements for practice, including practice notifications and related fees; the extent to which physician assistants may practice in this state in collaboration with physicians; the responsibilities of collaborating practitioners; physician assistant prescriptive authority; continuing education requirements; professional conduct requirements for physician assistants; complaint, investigation, audit and disciplinary procedures; and denial of licensure and disciplinary penalties.

The rule updates the drug diversion training to include additional information developed by the Governor's Council on Substance Abuse Prevention and Treatment; allows the practice notification to include prescribing, dispensing, and administering of controlled substances, prescription drugs, or medical devices; allows a physician assistant to prescribe schedule II drugs for no more than a three day supply with no refills; and removes the requirement that the physician assistant have certification from the

National Commission on Certification of Physician Assistants, but clarifies which title a certified PA may use.

With respect to practice requirements, new requirements are included that state the physician assistant may provide only those medical service for which they have been prepared by their education, training and experience and are competent to perform, consistent with sound medical practice and that will protect the health and safety of the patient. This may occur in any health care setting.

The rule provides that the physician assistant may not practice independent of a collaborating physician; must comply with applicable federal and state law governing the practice of physician assistants; and may practice in collaboration upon executing a practice notification.

The scope of practice is amended to reflect that the physician assistant can perform medical actions for which they have been trained and these acts include prescribing, dispensing, and administering controlled substances, prescription drugs, or medical devices.

West Virginia Board of Medicine – Board of Medicine Rules for Dispensing of Prescription Drugs by Practitioners, 11 CSR 05

The rule amends a current legislative rule which establishes the Board’s standards related to the office-based dispensing of prescription drugs by licensees of the Board. The amendments provide clarity, uniformity, and general clean-up. The reference to a practice agreement is removed. The rule also requires that an active practice notification be on file with the Board for the proposed controlled substance dispensing location.

West Virginia Board of Medicine – Continuing Education for Physicians and Podiatric Physicians, 11 CSR 06

The rule amends a current legislative rule that establishes the minimum continuing education requirements satisfactory to the Board for physicians and podiatric physicians.

The rule adds a requirement that information related to substance use disorder treatment referral be included in all drug diversion training and best practice prescribing of controlled substance training. Additionally, it also requires training on the impacts of stigma on treatment effectiveness, including the concept of addiction as a chronic disease

Finally, the rule permits podiatric physicians to satisfy continuing education requirements, except for the drug diversion training and best practice prescribing of controlled substances training requirement, by sitting for and passing a certification or recertification examination of the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery during the relevant period.

West Virginia Board of Medicine – Practitioner Requirements for Accessing the West Virginia Controlled Substances Monitoring Program Database, 11 CSR 10

The rule amends a current legislative rule which sets requirements for the licensees and registrants of the Board regarding obtaining and maintaining access to the West Virginia Controlled Substances Monitoring Program database. It eliminates obsolete definitions, updates and modifies existing definitions and adds a definition for benzodiazepine.

A new section 3 requires practitioners who prescribe certain controlled substances to obtain and maintain online or other electronic access to the database and to certify compliance to the Board at renewal.

Section 6 is amended to incorporate current administrative penalties as set forth in W. Va. Code §60A-9-5a.

West Virginia Board of Medicine – Establishment and Regulation of Limited License to Practice Medicine and Surgery at Certain State Veterans Nursing Home Facilities, 11 CSR 11

The rule amends a current legislative rule which establishes the qualifications and application process for a limited license to practice at a designated state veterans nursing home facility. It updates the rule in accordance with Senate Bill 372, which passed during the 2021 Regular Legislative Session regarding approved types of postgraduate clinical training for graduates of medical schools located in Canada, the United States and Puerto Rico and for graduates of international medical schools.

West Virginia Board of Medicine – Registration to Practice During Declared State of Emergency, 11 CSR 14

The rule amends a current legislative rule which establishes a registration process to allow out of state physicians or physician assistants to practice in WV during a declared state of emergency.

An emergency registration that is issued to an out-of-state or a state retired, or inactive physician or physician assistant, expires sixty days after issuance or five days after a declared state of emergency terminates, whichever is sooner. Thereafter, the emergency registrant must hold an active status West Virginia medical license or an interstate telehealth registration to practice medicine to West Virginia patients.

West Virginia Board of Medicine – Telehealth and Interstate Telehealth Registration for Physicians, Podiatric Physicians and Physician Assistants, 11 CSR 15

The rule is new. It establishes the scope of the practice for the provision of medical services via telehealth technologies and the process for physicians, podiatric physicians, and physicians' assistants to obtain an interstate telehealth registration with the Board. During the 2021 Regular Session, the Legislature enacted House Bill 2024 which created an interstate telehealth registration process for physicians and physician assistants who want to provide telehealth services in this state.

To obtain a registration an applicant must have an active license in good standing in another state and provide specified information. The physician registration fee is \$150, and the physician assistant registration fee is \$50. The registration is valid for one year.

The rule specifies the ways in which to establishes the patient provider relationship. Provider-patient relationships may not be established through text-based communications such as emails, internet questionnaires, text-based messaging, or other written forms of communication.

Once a provider-patient relationship has been established, providers may use any telemedicine technology that meets the standard of care and is appropriate for the patient presentation. The rule does not prohibit the use of text-based communications for responding to calls for existing patients and for a provider who has established a provider-patient relationship with the patient through an in-person encounter or in a medical emergency.

Telehealth providers must practice in a manner consistent with the practice of the provider's scope as well with the standards set forth in their profession. The standard of care for telehealth services is the same for in-person health care services.

For continued treatment of a patient solely via telemedicine technologies the standard of care requires a provider to verify that a patient has visited in-person within twelve months. This however does not apply to acute inpatient care, post-operative follow-up checks, behavioral medicine, addiction medicine, or

palliative care. This service may be suspended on a case-by-case basis. If suspended, the provider must document the reason for suspending the in-person visit requirement in the patient medical record. Telehealth providers must verify the identity and location of the patient.

Providers must determine if the patient's specific health issue is appropriate for telehealth technologies. They must obtain the consent of the patient to conduct telehealth services. Providers must conduct all appropriate evaluations and history of the patient consistent with the standard of care as well as create and maintain health care records for the patient.

When prescribing via telemedicine a provider must remain within the prescriptive authority of the providers profession. Telehealth providers are prohibited from prescribing a Schedule II controlled substance via telemedicine technologies unless they are an established patient of the prescribing telehealth provider's practice or the provider submits an order to dispense schedule II controlled substance to a hospital patient, other than in the emergency department, for immediate administration in a hospital or if a provider is treating patients who are minors, or if 18 years of age or older, who are enrolled in a primary or secondary education program and are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism or a traumatic brain injury in accordance with guidelines as set forth by organizations.

Telehealth provider who prescribes schedule II through V drugs must obtain online or other electronic access to the CSMP. Telehealth providers may not, based solely upon a telemedicine encounter, prescribe any drug with the intent of causing an abortion.

West Virginia Board of Osteopathic Medicine – Licensing Procedures for Osteopathic Physicians, 24 CSR 01

The rule amends a current legislative rule which establishes the operation of the Board and the regulation and licensing of osteopathic physicians. This filing makes changes to the drug diversion training and best practice prescribing of controlled substances training by requiring that the training also have elements of training on the administration of an opioid antagonist, information related to substance use disorder treatment referral, and recordation of attendance.

The amendments also add the ability of applicants to provide certain licensure documents to the board through the Federation of State Medical Boards Credential Verification Service.

West Virginia Board of Osteopathic Medicine – Osteopathic Physician Assistants, 24 CSR 02

The rule amends a current legislative rule which relates to physician assistants and their licensing, practice, complaint procedures and professional discipline, and continuing education. During the 2021 legislative session, the Legislature enacted Senate Bill 714 which updated the Physician Assistants Practice Act.

The rule eliminates the practice agreement between a physician assistant and the physician. The practice agreement was a document that was approved by the licensing board. In lieu of the practice agreement there is a practice notification which may be kept on file at the practice.

The practice notification may include prescribing, dispensing, and administering of controlled substances, prescription drugs, or medical devices. A Physician Assistant may prescribe a 3-day supply of schedule II drugs with no refills.

The rule removes the requirement that the physician assistant have certification from the National Commission on Certification of Physician Assistants but clarifies which title a certified Physician Assistant may use.

The physician assistant may not practice independent of a collaborating physician and may practice in collaboration upon executing a practice notification.

The scope of practice is amended to reflect that the physician assistant can perform medical actions for which they have been trained and these acts include prescribing, dispensing, and administering controlled substances, prescription drugs, or medical devices.

West Virginia Board of Osteopathic Medicine – Practitioner Requirements for Controlled Substances Licensure and Accessing the West Virginia Controlled Substances Monitoring Program Database, 24 CSR 07

The rule amends a current legislative rule which establishes the requirements for licensees and registrants of the West Virginia Board of Osteopathic Medicine regarding controlled substances licensure and accessing the West Virginia Controlled Substances Monitoring Act, W. Va. §60A-9. The purpose of the rule is to conform the rule changes made to the statute. The changes to the rule include adding the requirement that all practitioners who prescribe or dispense Schedule II, III, IV, or V controlled substances shall register with the CMSP and obtain and maintain online or other electronic access to the program database.

West Virginia Board of Osteopathic Medicine – Telehealth and Interstate Telehealth Registration for Osteopathic Physicians and Physician Assistants, 24 CSR 10

This new rule establishes the scope of the practice for the provision of medical services via telehealth technologies and the process for osteopathic physicians and osteopathic physicians' assistants to obtain an interstate telehealth registration with the Board. During the 2021 Regular Session, the Legislature enacted House Bill 2024 which created an interstate telehealth registration process for physicians and physician assistants who want to provide telehealth services in this state.

To obtain a registration an applicant must have an active license in good standing in another state and provide specified information. The osteopathic physician registration fee is \$150 and the osteopathic physician's assistant registration fee is \$50. The registration is valid for 1 year.

The rule specifies the ways in which to establishes the patient provider relationship. Provider-patient relationships may not be established through text-based communications such as emails, internet questionnaires, text-based messaging, or other written forms of communication.

Once a provider-patient relationship has been established, providers may use any telemedicine technology that meets the standard of care and is appropriate for the patient presentation. The rule does not prohibit the use of text-based communications for responding to calls for existing patients and for a provider who has established a provider-patient relationship with the patient through an in-person encounter or in a medical emergency.

Telehealth providers must practice in a manner consistent with the practice of the provider's scope as well with the standards set forth in their profession. The standard of care for telehealth services is the same for in-person health care services.

For continued treatment of a patient solely via telemedicine technologies the standard of care requires a provider to verify that a patient has visited in-person within twelve months. This however does not apply to acute inpatient care, post-operative follow-up checks, behavioral medicine, addiction medicine, or palliative care. This service may be suspended on a case-by-case basis. If suspended, the provider must document the reason for suspending the in-person visit requirement in the patient medical record. Telehealth providers must verify the identity and location of the patient.

Providers must determine if the patient's specific health issue is appropriate for telehealth technologies. They must obtain the consent of the patient to conduct telehealth services. Providers must conduct all appropriate evaluations and history of the patient consistent with the standard of care as well as create and maintain health care records for the patient.

When prescribing via telemedicine a provider must remain within the prescriptive authority of the providers profession. Telehealth providers are prohibited from prescribing a Schedule II controlled substance via telemedicine technologies unless they are an established patient of the prescribing telehealth provider's practice or the provider submits an order to dispense schedule II controlled substance to a hospital patient, other than in the emergency department, for immediate administration in a hospital or if a provider is treating patients who are minors, or if 18years of age or older, who are enrolled in a primary or secondary education program and are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism or a traumatic brain injury in accordance with guidelines as set forth by organizations.

Telehealth provider who prescribes schedule II through V drugs must obtain online or other electronic access to the CSMP. Telehealth providers may not, based solely upon a telemedicine encounter, prescribe any drug with the intent of causing an abortion.

Board of Pharmacy – Licensure and Practice of Pharmacy, 15 CSR 1

The rule amends a current legislative rule which governs the licensure and the practice of pharmacist care in West Virginia. The amendment removes the requirement a pharmacist wears a white coat and makes it optional.

Board of Pharmacy – Controlled Substances Monitoring Program, 15 CSR 8

The rule amends a current legislative rule which establishes requirements for the controlled substance monitoring database. The amendments implement the changes required by House Bill 2262 from the 2021 legislative rule, which requires pharmacists to check the Controlled Substance Monitoring Program when dispensing any Schedule II substance, opioid, or any benzodiazepine to a patient who is not suffering from a chronic illness. It also requires them to annually check the database if still dispensing the controlled substance.

Board of Pharmacy – Regulations Governing Pharmacists, 15 CSR 16

The rule amends a current legislative rule by cutting the biennial renewal fee for pharmacists 65 and older from \$100 to \$50.

Public Service Commission – Rules Governing the Occupancy of Customer-Provided Conduit, 150 CSR
37

The rule amends a current legislative rule by extending the sunset date for one year from August 1, 2022, to August 1, 2023.

West Virginia Board of Examiners for Registered Professional Nurses – Limited Prescriptive Authority for Nurses in Advanced Practice, 19 CSR 08

The rule amends a current legislative rule by extending the sunset date by five years.

West Virginia Board of Examiners for Registered Professional Nurses – Telehealth Practices, 19 CSR
16

This new rule sets forth the standards for the practice of telehealth by a registered nurse or advanced practice registered nurse. During the 2021 Regular Session, the Legislature enacted House Bill 2024 which created an interstate telehealth registration process for registered professional nurses and advanced practice registered nurses who want to provide telehealth services in this state.

To obtain a registration an applicant must have an active license in good standing in another state and provide specified information. The registration fee is \$100. The registration is valid for one year.

The rule specifies the ways in which to establishes the patient provider relationship. Provider-patient relationships may not be established through text-based communications such as emails, internet questionnaires, text-based messaging, or other written forms of communication.

Once a provider-patient relationship has been established, providers may use any telemedicine technology that meets the standard of care and is appropriate for the patient presentation. The rule does not prohibit the use of text-based communications for responding to calls for existing patients and for a provider who has established a provider-patient relationship with the patient through an in-person encounter or in a medical emergency.

Telehealth providers must practice in a manner consistent with the practice of the provider’s scope as well with the standards set forth in their profession. The standard of care for telehealth services is the same for in-person health care services.

For continued treatment of a patient solely via telemedicine technologies the standard of care requires a provider to verify that a patient has visited in-person within twelve months. This however does not apply to acute inpatient care, post-operative follow-up checks, behavioral medicine, addiction medicine, or palliative care. This service may be suspended on a case-by-case basis. If suspended, the provider must document the reason for suspending the in-person visit requirement in the patient medical record. Telehealth providers must verify the identity and location of the patient.

Providers must determine if the patient’s specific health issue is appropriate for telehealth technologies. They must obtain the consent of the patient to conduct telehealth services. Providers must conduct all appropriate evaluations and history of the patient consistent with the standard of care as well as create and maintain health care records for the patient.

When prescribing via telemedicine a provider must remain within the prescriptive authority of the providers profession. Telehealth providers are prohibited from prescribing a Schedule II controlled substance via telemedicine technologies unless they are an established patient of the prescribing telehealth provider’s practice or the provider submits an order to dispense schedule II controlled substance to a hospital patient, other than in the emergency department, for immediate administration in a hospital or if a provider is treating patients who are minors, or if 18 years of age or older, who are enrolled in a primary

or secondary education program and are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism or a traumatic brain injury in accordance with guidelines as set forth by organizations.

Telehealth provider who prescribes schedule II through V drugs must obtain online or other electronic access to the CSMP.

Board of Social Work Examiners – Qualifications for the Profession of Social Work, 25 CSR 01

The rule amends a current legislative rule in response to Enrolled Committee Substitute for House Bill 2024, which passed during the 2021 Regular Legislative Session. The rule defines terms related to telehealth and added two new sections. Section 5 relating to telehealth services sets forth licensing requirements, requires the social worker to be competent in the technology and skills necessary for providing telehealth, requires the social worker to follow agency procedures or develop and follow certain specified procedures and allows a social worker to provide telehealth when appropriate and in an ethical manner. Section 6 relates to interstate registration as a telehealth provider. It sets forth requirements for registration and biennial renewal, as well as the standard of care for the provision of telehealth services.

The rule also deletes subdivision 3.3.1, which provides that individuals seeking employment with Department of Health and Human Resources may be eligible for a provisional license with a degree in fields other than social work or social work-related fields. Enrolled Committee Substitute for Senate Bill 312, which passed in 2020, created a registration process for service workers within the Bureau for Children and Families.

Board of Social Work Examiners – Continuing Education for Social Workers and Providers, 25 CSR 05

The rule amends a current legislative rule. The rule adds definitions for the terms “asynchronous training” and “synchronous training”. It reduces the number of continuing education hours required biennially for licensure renewal from 40 to 30. It requires that at least 10 hours be in a synchronous format and states that no more than 10 hours may be obtained online using an asynchronous format.

West Virginia Board of Examiners for Speech Pathology and Audiology – Licensure of Speech Pathology and Audiology, 29 CSR 01

The rule is a current legislative rule which was amended in response to Enrolled Committee Substitute for House Bill 2024 which passed during the 2021 Regular Legislative Session. Where appropriate, reference is made to interstate tele-practice, including the addition of a \$175 renewal fee for registration. A new Section 16 relates to the registration, renewal standards of care and standards of conduct of an interstate tele-practice practitioner. That section defines terms, sets forth eligibility requirements for registration as a tele-practice practitioner, sets forth renewal requirements for registration, and sets forth standards of care for the provision of services.

CODE REFERENCE: West Virginia Code §64-9-1 et. seq – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: March 12, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

Senate Bill 427

Permitting WV Board of Medicine investigators to carry concealed weapon

This bill allows investigators and contractors for the Board of Medicine to carry a concealed firearm in the performance of their duties and establishes the criteria and procedures for such carry. These criteria include obtaining approval by a majority vote of the board, not being prohibited from possessing a firearm under state or federal law, obtaining and maintaining a concealed handgun license, and successfully completing a firearms training and certification program equivalent to that provided to officers attending an entry level law-enforcement certification course provided at the West Virginia State Police Academy.

CODE REFERENCE: West Virginia Code §30-3-19 – new

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: June 6, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 419

Establishing pilot project to evaluate impact of certain post-substance use disorder residential treatments

The bill creates a pilot program whereby the DHHR shall enter into contracts as a pilot with MCOs where a minimum of 15% of substance use disorder residential treatment contracts for facilities providing substance use disorder are paid based upon performance-based metrics.

The bill states that MCOs shall contract with a substance use disorder residential treatment facility and allow substance use disorder residential treatment facilities the option to be paid based upon performance-based metrics.

The metrics are listed in the existing bill, and include but are not limited to community supports, housing, job placement, and transportation. The bill permits an internal advisory group at DHHR to formulate performance metrics and rates to include the variables in the code as well as additional variables.

The bill provides data shall be reported monthly to the ODCP and a full-time person.

The bill provides the advisory committee shall evaluate the outcome of the pilot annually and adjust quality metrics to improve quality outcomes and assess the pilot for continuation.

The pilot will termination in 3 years unless it is recommended for further evaluation.

The reporting requirements contains a requirement for an actuarial analysis, and additional information on the overall performance of the contract, and any metrics that have been added in the previous fiscal year.

CODE REFERENCE: West Virginia Code §9-5-29 – new

DATE OF PASSAGE: March 7, 2022

EFFECTIVE DATE: June 5, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

Senate Bill 468

Creating Unborn Child with Down Syndrome Protection and Education Act

The bill provides that except in a medical emergency or a nonmedically viable fetus, a licensed medical professional may not perform or attempt to perform or induce an abortion, unless the patient acknowledges that the abortion is not being sought because of a disability.

The bill provides that if a licensed medical professional performs or induces an abortion on a fetus, licensed medical professional shall, within 15 days of the procedure, cause to be filed with the commissioner, on a form supplied by the commissioner, a report detailing the following:

- Date the abortion the abortion was performed;
- Specific method of the abortion;
- A statement from the patient confirming that the reason for the abortion was not because of the disability;
- Probable health consequences of the abortion to the patient;
- Whether a medical emergency existed; and

The licensed medical professional shall sign the form as his or her attestation under oath.

The bill provides for penalties.

CODE REFERENCE: West Virginia Code §16-2Q-1 – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 21, 2022

Senate Bill 470

Relating generally to health care decisions

Senate Bill 470 modifies eight sections within the West Virginia Health Care Decisions Act and one section within the Do Not Resuscitate Act.

In §16-30-3, the bill removes the definition of the term “persistent vegetative state”. It also removes this term from the definition of “life-prolonging intervention” and from the statutory forms for a living will and combined medical power of attorney and living will provided in §16-30-4. It also removes this term from provisions governing a physician’s duty with respect to a patient who has executed a living will or combined medical power of attorney and living will in §16-30-19.

In §16-30-3, the bill renames the defined term “physician orders for scope of treatment (POST) form” as “portable orders for scope of treatment (POST) form” and adds advanced practice registered nurses (APRNs) and physician assistants (PAs) to this definition as providers who may issue the orders contained in the POST form. It also updates references to this term and to APRNs and PAs throughout the bill.

The bill adds “combined medical power of attorney and living will” to other references to living wills and medical powers of attorney throughout. This includes adding “combined medical power of attorney and living will” to the definition of the term “principal” in §16-30-3 and extending existing authority and prohibitions applicable to executing a living will and medical power of attorney to a combined medical power of attorney and living will in §16-30-4.

The bill adds language to the statutory form for a living will and combined medical power of attorney and living will in §16-30-4 which provides an express acknowledgment by the principal that he or she is agreeing to the removal or refusal of CPR, ventilator, dialysis, and medically administered food and fluids. It also expressly permits oral food and fluids to be offered as desired and can be tolerated.

The bill modifies the special directives or limitations available on the statutory form for a living will, power of attorney, and combined medical power attorney and living will in §16-30-4. It also adds space for the address of the principal to be provided beneath his or her signature.

The bill adds language in the statutory form for combined medical power of attorney and living will in §16-30-4 which separates living will provisions applicable when the principal is in a terminal condition, and medical power of attorney provisions applicable when he or she is not in a terminal condition, and any special directives or limitations that the principal wishes to have on either of those powers.

The bill includes a new subsection (j) to §16-30-4 clarifying that living will, medical power of attorney, and combined medical power of attorney and living will documents executed prior to the effective date of these amendments remain effective and that the amendments apply to documents executed, amended, or adjusted on or after January 1, 2023. It further requires health care facilities and health care providers which utilize these documents must update their forms on or before this date.

In §16-30-19(c), the bill updates an existing requirement for inpatient health care facilities to develop a system to visibly identify a person’s chart which contains a living will or medical power of attorney, so that the requirement also includes a combined medical power of attorney and living will and POST forms.

In §16-30-21, the bill adds mental health advance directives, medical orders (portable orders for scope of treatment or do-not-resuscitate cards), and similar advance directives and medical orders forms to the list of documents executed in another state which are subject to reciprocity provisions under the West Virginia Health Care Decisions Act.

The bill recognizes the authority of APRNs and PAs with respect to the provisions governing POST forms in §16-03-25.

Lastly, the bill adds a reference to combined medial power of attorney and living will and removes a reference to persistent vegetative state in §16-30C-5 (Do Not Resuscitate Act) in line with the above.

CODE REFERENCE: West Virginia Code §16-30-3, §16-30-4, §16-30-5, §16-30-10, §16-30-13, §16-30-19, §16-30-21, §16-30-25, and §16-30C-5 – amended

DATE OF PASSAGE: March 9, 2022

EFFECTIVE DATE: June 7, 2022

ACTION BY GOVERNOR: Signed March 23, 2022



Senate Bill 518

Allowing nurses licensed in another state to practice in WV

The bill makes changes to the board composition, restructures the duties of the board, and requires the board to appoint nine members to the Nursing Shortage Study Commission to study the nursing shortage and make recommendations to the Joint Committee on Health by December 1, 2022. This shall terminate on January 1, 2023.

CODE REFERENCE: West Virginia Code §30-7-1a, §30-7-15e, and §30-7-20 – repealed; §30-7-3, §30-7-4, §30-7-6, §30-7-7, §30-7-8, §30-7-8a, and §30-7-20 – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: March 12, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

Senate Bill 553

Relating to powers of WV Health Care Authority

Senate Bill 553 requires the Health Care Authority to promulgate legislative rules and removes its authority to adopt, amend, and repeal policy guidelines. The bill expressly requires the Authority to propose legislative rules relating to the Uniform Bill database.

Senate Bill 553 also requires the secretary of DHHR, to the extent he or she assumes or has already assumed the Health Care Authority's powers and duties over the health care data repository program, to propose legislative rules relating to that program.

In short, Senate Bill 553 requires the Health Care Authority, or the DHHR secretary when he or she assumes its responsibilities, to propose legislative rules instead of exercising the Authority's powers and duties through policy guidelines that are not reviewed or reviewable by the Legislature.

CODE REFERENCE: West Virginia Code §16-29B-8, §16-29B-24, §16-29B-25 – amended

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: March 8, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

Senate Bill 568

Relating to health insurance loss ratio information

The bill requires loss ratio information to be made available upon request of an insured relating to Group Accident and Sickness Insurance; Hospital Service Corporations, Medical Service Corporations, and Health Service Corporations; Health Care Corporations; and Health Maintenance Organizations. The bill exempts Dental Service Corporations from the provisions of the sections.

CODE REFERENCE: West Virginia Code §33-16-3c, §33-24-6a, §33-25-10a, and §33-25A-7b – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

Senate Bill 585

Creating administrative medicine license for physicians not practicing clinical medicine

The bill creates an administrative medicine license. This is a medical license that allows a physician to practice administrative medicine in such areas as managing the clinical operations and other business activities related to the delivery of health care services.

The West Virginia Board of Medicine may issue a license to a physician who completes an application pays the fee and meets all qualifications for licensure and demonstrates competency to practice administrative medicine. An administrative licensee may not practice clinical medicine.

The bill gives the board the ability to propose emergency rules.

CODE REFERENCE: West Virginia Code §30-3-11c – new

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: June 8, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 603

Prohibiting licensure and re-licensure in WV if applicant is prohibited from practicing in another jurisdiction

The bill provides that board shall not issue an initial license, reinstate, or reactivate a license, to any individual whose license has been revoked, suspended, surrendered, or deactivated in another state based upon conduct which is substantially equivalent to an act of unprofessional conduct prohibited by the code or the board's legislative rules, until reinstatement of his or her license in the state.

CODE REFERENCE: West Virginia Code §30-3-10 – amended

EFFECTIVE DATE: June 6, 2022

DATE OF PASSAGE: March 8, 2022

ACTION BY GOVERNOR: Signed March 23, 2022

Senate Bill 606

Relating to WV Medical Practice Act

Senate Bill 606 modifies provisions of the West Virginia Medical Practice Act which govern professional discipline of physicians and podiatrists.

The bill adds a new reporting requirement to subsection (b)(5), imposing a duty on a healthcare provider licensed or authorized by the Board of Medicine to submit a written report to the Board if he or she reasonably believes a provider has engaged in certain conduct. The bill specifies five categories of provider conduct which are reportable under this provision. The bill requires the report to be submitted within 30 days of the incident itself or the provider's subsequent knowledge of same. It establishes failure to report as unprofessional conduct which is grounds for disciplinary action. The bill provides an exception to this reporting requirement for physicians who obtain otherwise reportable information exclusively while functioning as an executive director or employee of a board-approved professional health program.

The bill provides immunity from civil liability for a person who submit any report under subsection (b) in good faith and without fraud or malice. It establishes bad faith, fraudulent, or malicious reporting as unprofessional conduct and grounds for disciplinary action.

The bill expands the reasons the Board may deny a license application or discipline a provider under subsection (c) to include engaging in other sexual misconduct and failing to comply with a reporting requirement under subsection (b).

Lastly, in new subsection (u), the bill provides rulemaking authority to the Board to define sexual misconduct and identify prohibited professional misconduct, including sexual misconduct, for purposes of denying an application or disciplining a provider.

CODE REFERENCE: West Virginia Code §30-3-14 – amended

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

Senate Bill 647

Prohibiting discrimination in organ donation process

This bill creates a new article which is entitled “Nondiscrimination Relating To Access to Organ Transplantation”. It sets forth legislative intent and defines terms. It prohibits a covered entity from, based on a qualified individuals mental or physical disability:

- Determining the qualified individual ineligible to receive an anatomical gift or organ transplant;
- Denying a qualified individual medical and related services, relating to organ transplantation;
- Refusing to refer the qualified individual to a transplant center or other related specialist for the purpose of evaluation or receipt of an organ transplant;
- Refusing to place a qualified individual on an organ transplant waiting list or placing him or her at a lower-priority position on the list than he or she would have been placed if not for his or her disability; or
- Declining insurance coverage to any qualified individual for any procedure associated with the receipt of an anatomical gift, including post-transplantation care.

This bill also provides that an individual’s disability may be considered in certain circumstances, requires covered entities to make necessary reasonable modifications to their policies, practices, or procedures, and requires covered entities to take the steps necessary to ensure a qualified individual is not denied services because of the absence of auxiliary aids and services except in certain circumstances.

Lastly, the bill states that the remedy for violation of this article are the same as those under the Americans with Disabilities Act. It also states that a court should accord priority on its calendar expeditiously for an action to enforce compliance the article.

CODE REFERENCE: West Virginia Code §16-65-1 et. seq – new

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 21, 2022

House Bill 2817

Donated Drug Repository Program

The bill creates a new chapter of code entitled the Donated Drug Repository Program. The bill defines terms. The Board is the WV Board of Pharmacy. The terms donor includes a member of the public, or any entity legally authorized to possess drugs with a license or permit in good standing. Drugs means both prescription and nonprescription drugs. Eligible patient means an indigent person. However, if the recipients supply of donated drugs exceeds the need for donated drugs by indigent persons, then any other person in need of a particular drug can be an eligible patient.

The bill provides for waivers for donors and eligible recipients from any rule related to this program. The bill provides that any person or entity may dispose of an eligible drug by donating it to an eligible recipient. The bill provides an eligible recipient may receive drugs from a donor. The bill provides that an eligible recipient may accept drugs that are in tamper-resistant packaging and drugs that have a tamper evident seal. The drugs that may be dispensed are prescription drugs that do not expire before the completion of medication by the eligible patient based on the prescribing health care professionals' directions for use and for over-the-counter drugs, based upon the manufacturer's label and the drugs were donated in a unopened tamper-evident packaging. The bill provides that controlled substances and drugs subject to the FDA managed risk and evaluation mitigate on strategy may not be donated. Eligible drugs are drugs believed to be unadulterated. The bill lists the eligible recipients and requires the board to publish a list on its website. Participating entities shall make all records available within five business days.

The bill defines the information that needs to be collected from a new donor, including whether the donor meets the definition of donor; the donors name, address, phone number and license number. The bill provides the donor shall only make donations in accordance with the program. The donor shall ensure the integrity of any drug requiring temperature control. The bill sets forth requirements for storage and inventory. The bill provides donated drugs shall be kept separate from other inventory and that drugs may be repackaged as necessary for storage, replenishment, dispensing and administration.

With respect to dispensing the drugs, it must be consistent with law. The drugs must be dispensed pursuant to a valid prescription. The patient shall be provided appropriate counseling. The bill provides that an eligible recipient may further donate unused prescription drugs do or receive unused prescription drugs from another eligible recipient. The bill provides an inventory shall be kept unless both eligible recipients are under common ownership and control.

The bill provides that an eligible recipient shall dispose of drugs that do not meet the requirements of the program by returning them to the donor, destroying the drugs in an incinerator, or transfer of the drug to a reverse distributor. The bill provides that donated drugs may not be resold and shall be considered nonsalable. A handling fee may be charged. The fee may not exceed the reasonable costs of participating in the program. Dispensed drugs shall be repackaged in a new contained and previous patient information and pharmacy information shall be redacted. An expiration date is required for all drugs.

The bill provides for rulemaking, and incorporates language regarding liability protection.

CODE REFERENCE: West Virginia Code §60B-1-1 through §60B-1-8 – new

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4012

Prohibiting the showing of proof of a COVID-19 vaccination

The bill addresses exemptions from compulsory COVID-19 vaccinations. It adds a requirement that religious beliefs must be “sincerely held”. It excludes from the definition of “covered employer” any Medicare or Medicaid certified facilities which are subject to enforceable federal regulations contrary to the requirements of §16-3-4b.

The new section created in this bill, §16-3-4c, provides that no state or local governmental official, entity, or agency may require proof of vaccination as a condition of entering the premises of a state or local government entity or utilizing services provided by a state or local government entity. There is an exception that states if any federal law or regulation requires proof of vaccination as a condition of entering, the provisions of this section do not apply. This provision also does not apply to a private entity where the local governmental unit primarily serves as a property owner receiving rental payments. It also provides that no hospital or state institution of higher learning may require proof of vaccination as a condition of entering the premises. Provided, that when federal law or regulation requires proof of vaccination as a condition of entering or participation in a course of study requires vaccination, the provisions of this section are inapplicable.

CODE REFERENCE: West Virginia Code §16-3-4b – amended; §16-3-4c – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: March 12, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4059

Clarifying that new Department of Health and Human Resources' Deputy Commissioners are exempt from civil service

The bill creates an exemption from civil services for policy making decision which would now include newly hired Deputy Commissioners within the Department of Health and Human Resources. The bill also adds attorneys as exempt positions to resolve a code conflict.

CODE REFERENCE: West Virginia Code §29-6-4 – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: March 12, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4060

Repealing outdated sections of code relating to health

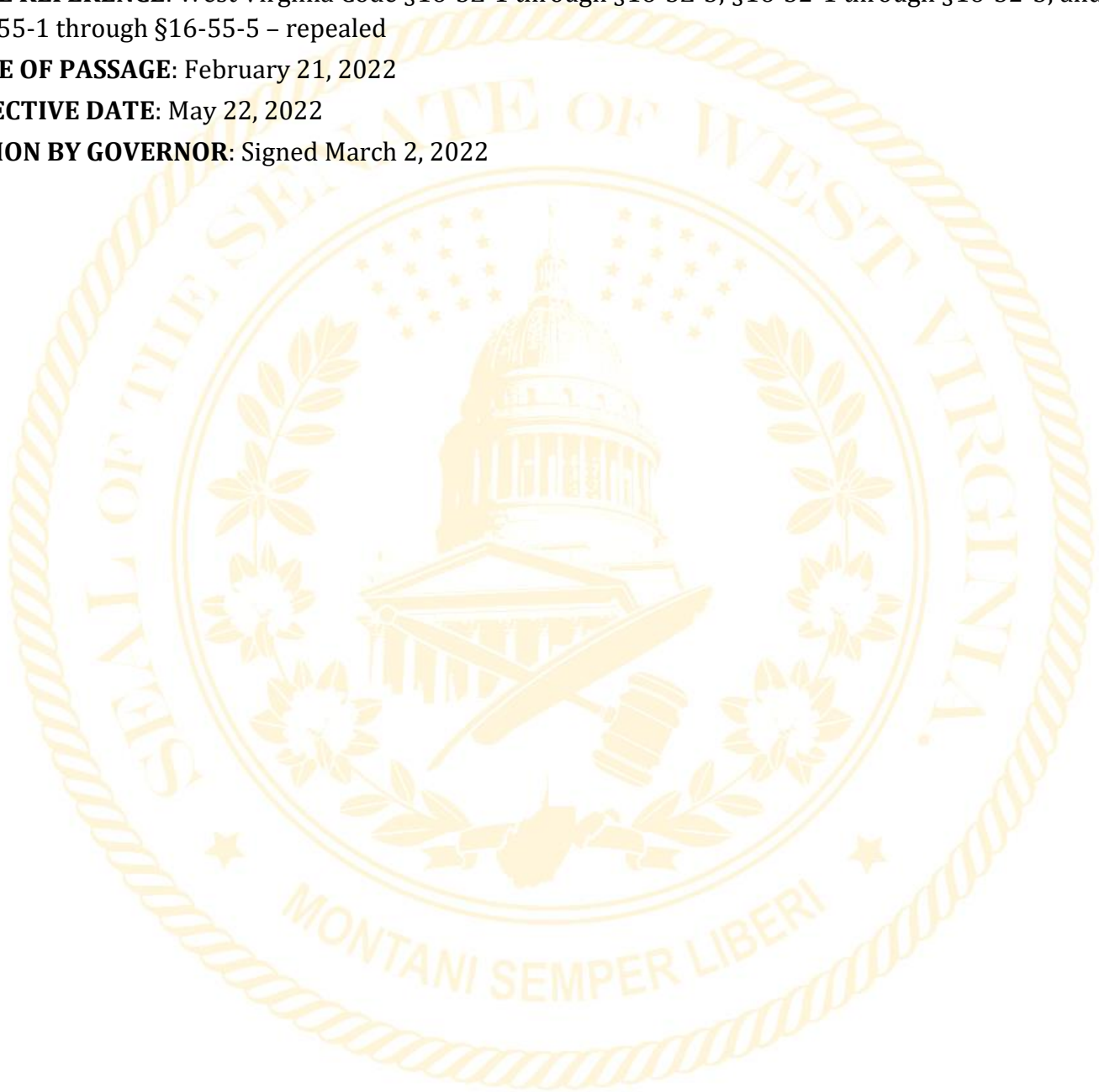
The purpose of this bill is repeal outdated sections of code relating to the State Coalition for Diabetes Management, the State Coalition for Responsible Pain Management, and the State Advisory Coalition for Palliative Care.

CODE REFERENCE: West Virginia Code §16-5Z-1 through §16-5Z-5; §16-52-1 through §16-52-5; and §16-55-1 through §16-55-5 – repealed

DATE OF PASSAGE: February 21, 2022

EFFECTIVE DATE: May 22, 2022

ACTION BY GOVERNOR: Signed March 2, 2022



House Bill 4112

Provide consumers a choice for pharmacy services

The bill relates to pharmacy benefits managers (PBMs). The definition of covered entity is deleted in the definitions and throughout the bill and replaced with health benefit plan. A new definition of “health care payor” or “payor” is added. It means a health insurance company, a health maintenance organization, a hospital, medical, or dental corporation, a health care corporation, an entity that provides, administers, or manages a self-funded health benefit plan, including a governmental plan, or any other payor that provides prescription drug coverages, including a workers’ compensation insurer. Health care payor does not include an insurer that provides coverage under a policy of casualty or property insurance. The definition of specialty drug is amended to reflect that a specialty drug is a drug means a drug used to treat a chronic and complex, or rare medical conditions and requiring special handling or administration, provider care coordination, or patient education that cannot be provided by a non-specialty pharmacy or pharmacist.

With respect to pharmacy audits, the on-site requirement is deleted. With respect to the definition of a rebate, the terms does not include any discount that may be provided to or made to any 340B entity through such program.

The definition of third party is deleted.

Technical changes are made throughout the bill.

Language stating that a pharmacy benefit manage may only directly or indirectly hold a pharmacy, a pharmacist, or a pharmacy technician responsible for a fee related to the adjustment of a claim if the fee is identified, reported and specifically explained, or the total amount of the fee is apparent at the point of sale and not adjusted between the point of sale and the issuance of the remittance advice is deleted.

With respect to the 340B language, a proviso is added stating that nothing in this section shall be construed to prohibit the Medicaid program or a Medicaid managed care organization from preventing duplicate billing discounts. The provisions of this sections apply to PEIA. This same language applies to the discriminatory practice provision language.

Language is stating that filed methodologies shall comply with the provisions of the code and pharmacy benefits managers shall not enter into a contract with a pharmacy for reimbursement not permissible. This section refers to NACAC and WAC pricing.

With respect to the freedom of choice provisions, language has been deleted applying the provisions to the health benefit plan. Language is deleted restricting access to the PBM’s affiliate. The definition of health benefit plan is deleted. The last section of the bill is re-numbered.

CODE REFERENCE: West Virginia Code §33-51-3, §33-51-8, §33-51-9, §33-51-11 – amended; §33-51-13 – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4113

Public Health definitions and powers of secretary and commissioner

The purpose of this bill is to modernize the law related to local health departments. The bill edits and defines terms, including basic public health services that deletes the three areas of basic public health services. The bill deletes references to licensing boards, program plan, state advisory council on public health, and state board of health.

With respect to the powers and duties of the Secretary, the Commissioner will retain authority to account for money in an account for fees deposited related to licensure and the secretary will no longer share this duty. The Secretary has been given permissive authority to appoint advisory councils.

With respect to rulemaking states that rules shall be legislative rules. The rulemaking section deletes outdated language related to health departments funding amount but inserts language stating that the provisions are in effect until the performance standard funding formula is created and established by legislative rule. Emergency rulemaking language is deleted and so is language relate to general rulemaking for other health related matters which the department is authorized and other general rulemaking ability. Language related to the appointment of advisory councils is deleted.

With respect to the State Health Officer, the qualifications have been revised. The word “physician” has been removed from the qualifications and removes language stating that the commissioner shall have not less than four years’ experience in health services administration or a related field.

With respect to the powers of the commissioner, stylistic changes were made in this section. Additionally, the commissioner’s ability to monitor the administrative of local health boards was removed. The Commissioner was given authority to transfer patients between hospitals and facilities without this act being at the direction of the secretary. The commissioner is to make periodic reports to the legislature and the governor relative to specific areas of public health without this act being at the direction of the secretary. The Commissioner can buy and sell land without the consent of the Governor or Secretary and is not required to place the proceeds of the sale into the hospital services account. Language that requires treatment and rehabilitation of alcoholics and drug abusers is deleted. Language requiring quarterly reporting of sudden infant death syndrome. Language is deleted requiring the Commissioner to establish and fund a uniform health professionals data system and maintain data on all health professionals in the state.

Language is added to the Commissioners duties to require the Commissioner to establish within the Bureau of Public Health a Center for Local Health that shall enhance the quality if essential services provided by local board of health; provide technical assistance and consultation to local board of health; allocate and distribute funding based upon performance based standards; provide technical assistance to the local public health workforce; facilitate bi-directional communication; establish a uniform statewide computer system for the reporting of public health data; inventory the services provided by local board of health; support sharing of services between local board of health; create performance based evaluation system based on standards established by legislative rule and provide quarterly training to ensure consistency in the application of state laws, legislative rules, and local health department rules; and enforce compliance with performance based standards.

A section is repealed relating to the powers and duties of the commissioner to cooperate with state health planning and development agencies, along with any federal government agencies in hospital or health facility programs.

With respect to the disposition of permit and license fees, the Commissioner is no longer required to make an annual report to the Legislature on the health facility licensing account, including the previous fiscal year's expenditures and projected expenditures for the next fiscal year.

With respect to the receipt and disbursement of federal aid and other moneys, the commissioner is not subject to the direction of the secretary in accepting and receiving funding. Additionally, all money shall be deposited by the commissioner in the State Treasury rather than the Secretary.

A section related to hospital services revenue account and health facilities long range plans is repealed. This section required money to be deposited into this account any fees received by a facility owned and operated by the department. It also required a five-year long-range plan be developed by the Secretary and updated every two years.

With respect to Training of employees, language is deleted referencing upon review of the employees' personnel records, limiting the training to nine months in any four year period, in the field or vocation in which the employee is engaged, subject to the approval of the secretary and a provision that the employee receive training at a place the commissioner deems suitable.

CODE REFERENCE: West Virginia Code §16-1-8, §16-1-13, and §16-1-21 – repealed; §16-1-2, §16-1-3, §16-1-4, §16-1-5, §16-1-6, §16-1-7, §16-1-10, §16-1-11, §16-1-12, §16-1-14, §16-2-2, §16-2-10, §16-2-11, §16-2-12, §16-2-13, and §16-2-14-2 – amended

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: March 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4126

Authorizing certain agencies of the Department of Health and Human Resources to promulgate legislative rules

This Committee Substitute contains the Department of Health rules. It is known as Bundle 5 and contains 15 rules.

Department of Health and Human Resources – Methods and Standards for Chemical Tests for Intoxication, 64 CSR 10

The rule amends an existing legislative rule. The rule establishes methods and standards relating to implied consent for a chemical test for intoxication. The rule is applicable to all law enforcement agencies and personnel engaging in breath, blood, urine and/or drug analysis in this state, and to those persons suspected of driving under the influence of alcohol or drugs or both.

Under this rule, the definitions for “evidential test sequence” and “simulator solution” have been amended. Definitions have been added for the terms “Alveolar solution” and “secondary breath analysis”

In subsection 5.3. the word “solely” which previously restricted the use of the preliminary alcohol breath test to being used for the purpose of guiding the officer in deciding whether an arrest should be made is struck and added language is added permitting usage of this test to also include “to determine if alcohol is the cause for impairment.”

Section 9 relating to urine analysis has been deleted, as well as any reference to urine analysis in the rule.

Department of Health and Human Resources – Hospital Licensure, 64 CSR 12

The rule amends a current legislative rule. The rule establishes the standards and procedures for the licensing of hospitals and extended care facilities operated in connection with a hospital. It applies to any person, partnership, association, corporation, state, or local government unit, political subdivision, division, department, board, or agency that establishes, maintains, or operates a hospital or an extended care unit in connection with a hospital as defined in statute.

Subdivision 7.3.11 was changed to incorporate an amendment requiring that all therapeutic diets be recommended by a qualified dietician. Currently, they must be prescribed by the attending practitioner.

Subsection 8.7. references the anesthesia department. Duplicative language is removed and language is added stating that anesthesia may be administered by a licensed practitioner permitted by state law to administer “anesthesia, a certified registered nurse anesthetist as permitted by state law, or other professionals as permitted by the medical staff and state law.”

Department of Health and Human Resources – Child Lead Screening, 64 CSR 42

The rule amends a current legislative rule. The rule establishes and implements a statewide childhood lead poisoning screening and identification program. It applies to physicians, hospitals, health care facilities, and health care providers who conduct or oversee medical examinations of children under the age of six years.

Subsection 4.1 has been amended to remove qualifying language resulting in the requirement that all children before the age of six shall have a screening test.

Subdivision 4.1.b. has been amended by adding language requiring the Office of Maternal, Child and Family Health to ensure the laboratory results are incorporated in the Immunization Registry within the lead module provided by the BPH for health care provider reference.

Subdivision 4.1.d. stating that if a child is determined to be at-risk for lead poisoning the health care provider shall perform or authorize a blood test has been deleted.

Section 5 has been amended to reduce the lead levels in the confirmatory blood tests. In subdivision 5.3.a., children with a blood level of greater than or equal to five, rather than the existing ten micrograms per deciliter must be referred to an “appropriate” program “based upon on age and concern”. Subdivision 5.3.b. lowers the blood levels from greater than or equal to eight micrograms per deciliter, rather than the existing 15 micrograms per deciliter, in children with two consecutive blood lead levels and removes references that “all children with blood lead levels of greater than or equal to 20 micrograms per deciliter” be referred to environmental assessments and “nurse home visits”. As a result of these edits, children with two consecutive blood lead levels of greater than or equal to 8 micrograms per deciliter must be referred to environmental assessments within two days of confirmation.

Subdivision 5.3.c. requires that all children with an elevated blood level greater than or equal to five micrograms per deciliter, rather than the existing ten micrograms per deciliter, have a follow up blood level screening test within three months rather than every three months.

Subsection 7.1 is amended to provide that capillary blood samples may be analyzed using an approved Clinical Laboratory improvements amendments waived lead testing point of care system.

Subsection 7.3 requires laboratories processing blood lead samples to electronically submit data to the Office of Maternal, Child and Family Health.

Department of Health and Human Resources – Food Manufacturing Facilities, 64 CSR 43

The rule amends a current legislative rule, establishes the minimum requirements for the design, construction, management, and operation of food manufacturing facilities. It applies to food manufacturing facilities engaged in wholesale operations, except food manufacturing facilities under the jurisdiction of the West Virginia Department of Agriculture.

Section 3 addresses incorporation by reference of the federal code of regulations. This section amends the references to the applicable federal code and removes the applicable date of the reference.

Subdivision 4.2.2. has an added requirement for labels and requires that a label comply with the food labeling requirements of 21 CFR 101 for products sold in interstate commerce. Subsection 4.3 has an added requirement that facilities comply with the CFR regarding better process control schools, process control individual training, and appropriate food safety training. Requirements regarding refrigeration temperature have been deleted.

Section 6, this section addresses inspections. It has been amended to require the Commissioner to perform one or more preproduction inspections to verify that a food manufacturing facility is constructed and equipped in accordance with the plans and modifications as approved by the commissioner

Department of Health and Human Resources – Sewage Treatment and Collection System Design Standard, 64 CSR 47

The rule amends a current legislative rule, setting standards for the construction or operation of sewage or collection systems requiring approval by the Bureau for Public Health.

Senate Bill 240 which passed during the 2020 Regular Session of the Legislature required hotels and restaurants to secure manhole covers, provided methods for securing manhole covers, authorized the Commissioner of the Bureau for Public Health to specify methods of limiting access to the manhole.

Section 10 relates to grease traps. Subsections 10.7 through 10.9 are new. They require that grease traps with manhole covers be designed to withstand expected loads and prevent access by children. The manhole cover must be secured by a bolt or locking mechanism and be constructed of round or cast iron or similar construction with sufficient weight to prevent unauthorized access. The Commissioner may specify either method of limiting access to the manhole. A hotel or restaurant must ensure that a grease trap manhole is closed and secured or locked, if applicable, at all times, except when accessed for pumping or maintenance.

Finally, Table 64-46B-B, Table 64-47-G, and 64-47-H have been amended by adding language regarding BOD5 and stating that it's the appropriate scientific method of accurately measuring dissolved oxygen consumption, by comparison of dissolved oxygen in a sample at the beginning and at the end of a five-day period in reference to biochemical oxygen demand.

Department of Health and Human Resources – Emergency Medical Services, 64 CSR 48

The rule amends a current legislative rule. It ensures adequate provision of medical services to the residents of West Virginia and provides clear direction to emergency medical service personnel and agencies in West Virginia. It applies to emergency medical service personnel and agencies and to all other persons engaging in the provision of emergency medical services in West Virginia.

Paragraph 4.5.9.c. was modified to reflect that a fire department certified by the West Virginia State Fire Commission is not subject to licensure under this rule if it only provides basic life support services pursuant to an agreement with an EMS agency that addresses medical direction, training, quality assurance, and liability insurance.

Subdivision 6.2.15. relating to the Governor's State of Emergency declared March 16, 2020, has been deleted.

Department of Health and Human Resources – Clinical Laboratory Practitioner Licensure and Certification, 64 CSR 57

The rule amends a current legislative rule and sets forth procedures for the licensing of clinical laboratory practitioners and to establish practices for the use of unlicensed persons to perform the work of clinical laboratory practitioners by health care facilities. This rule applies more broadly to clinical laboratory practitioners who perform non-waived clinical laboratory tests as defined in the Clinical Laboratory Improvement Amendments (CLIA) this includes clinical laboratory consultants, directors, supervisors, or testing personnel who perform non-waived testing or manipulate, and report data obtained from laboratories.

Section 1 which defines the scope of the rule has been amended to remove laboratory technicians and medical laboratory scientists from the scope of the rule.

Subdivision 1.6.c. was amended to increase the exemptions to the rule to include: an individual employed in a federal clinical laboratory; a medical doctor, doctor of osteopathy, or podiatrist licensed to practice in West Virginia; a doctor of philosophy performing laboratory testing within the scope of his or her board certification; an individual performing laboratory testing for a CLIA-exempt laboratory; an individual solely performing forensic laboratory testing; and an individual solely performing during testing for a laboratory certified by the Substance Abuse and Mental Health Administration.

Subsection 2.1. has been amended by adding numerous boards under the definition of "Certifying agency. The definition of clinical laboratory practitioner was amended to include medical laboratory

technicians, histologists, pathologist assistants and trainees and the exclusions from the definition were removed. New definitions were added for the terms “grossing”, “histologist” and “pathology assistant”.

Section 3 was amended to update references to federal regulations.

Subsection 4.3 that prohibited a clinical laboratory practitioner from performing laboratory testing as a trainee for more than one year was deleted. A provision was added stating that a trainee license may only be issued to an applicant that is verified to be employed or offered employment in a clinical laboratory testing facility or that is enrolled in a laboratory training program.

With respect to section 5, this section addresses licensure requirements, duration and renewal. Subsection 5.1 removes language references specific types of practitioners. Subdivision 5.1.a. is removed and 5.1.b is re-numbered. The specific qualifications set forth in subdivision 5.1.b are removed and a general reference to “qualifying education” is used to replace the specific qualifications. A new subdivision 5.1.b. is creating requiring an applicant submit a job description or education for which certification is sought.

Subsection 5.2. addresses the application process for licensure as a clinical laboratory practitioner-medical laboratory scientist. It provides that unless the applicant provides verification that he or she has met one of the substitute criteria permitted by CLIA for testing, then he or she shall provide the documentation specified in this subsection. Subdivision 5.2.a. specifies that an applicant must earn his or her bachelor’s degree from a NAACLS accredited program. Additional criteria that an applicant must satisfy has been added to Subdivision 5.2.b. including: that the applicant was “previously certified as a medical laboratory technician by a certifying agency, obtained a bachelor’s degree from an accredited institution”, and has passed a national certification examination administered by a certifying agency”. Subdivision 5.2.c. incorporates by reference the skills required by CLIA and deletes the specific skills from the subdivision.

Subsection 5.3 addresses the application process for a clinical laboratory technician-cytotechnologist to become licensed. It provides that unless the applicant provides verification that he or she has met one of the substitute criteria permitted by CLIA for testing, then he or she shall provide the documentation specified in this subsection. Subdivision 5.2.a. specifies that an applicant must earn his or her associate degree from a NAACLS accredited program. It incorporates by reference the skills required by CLIA and deletes the specific skills from the subdivision.

Subsection 5.5. addresses the criteria for licensure of a clinical laboratory practitioner-pathologist assistant. This section specifies that unless the applicant provides verification that they have met one of the substitute criteria permitted by CLIA for testing, then he or she shall provide the documentation required in this section. The criteria that must be demonstrated are new criteria and include the following: graduating from a pathologist assistant program accredited by NAACLS; and certification by a certifying agency.

Subsection 5.6 addresses the criteria for licensure of a clinical laboratory practitioner-histologist. This section specifies that unless the applicant provides verification that they have met one of the substitute criteria permitted by CLIA for testing, then he or she must provide the documentation required in this section. The criteria that must be demonstrated include that the applicant meets the requirements of CLIA for high complexity testing personnel and has passed a national histotechnologist or histo-technician certification examination administered by a certifying agency or has at least one year of pertinent full-time experience or training in the gross examination of human tissue specimens performed under the supervision of a pathologist.

Subsection 5.7 addresses the licensure for a point of care technician and removes references to general language at the beginning of the rule and strikes the skills requirements. The skills requirements for the technician are incorporated by reference in subdivision 5.7.c.

Subsection 5.8 sets forth new criteria for licensure of a clinical laboratory practitioner-trainee. The trainee shall document that he or she: is employed in a clinical laboratory which holds a CLIA certificate other than a waiver certificate; has earned an associate degree from an accredited institution in medical technology/medical laboratory science but has not met requirements for national certification. The rule proposes various educational alternatives to medical technology/medical laboratory science as a means for licensure and requires written verification by the laboratory director or program director to provide the skills required by CLIA. The rule provides that a trainee may qualify for full licensure upon completion of one year of training/experience and submission of the “verification of competency” document to be completed by the laboratory director. The rule provides that trainees licensed under specific provisions are expected to obtain the required national certification within one year of obtaining the trainee license and any application for renewal without national certification shall provide documented attempts to become certified. The rule provides that the trainee may be certified no more than twice and may not be licensed as a trainee from more than three years.

Subdivision 5.11.h. adds a fee of \$35 for payments returned for non-sufficient funds.

Subsection 8.3 adds as grounds for revocation that a person has been found to have intentionally falsified laboratory results or to have engaged in negligent practices.

Department of Health and Human Resources – Clandestine Drug Laboratory Remediation, 64 CSR 92

The rule amends a current legislative rule and sets forth procedures and standards for the licensure and training of persons who engage in activities related to the remediation of clandestine drug laboratories. It also identifies the responsibilities of residential property owners and law enforcement with regard to the identification and remediation of clandestine drug laboratories. This rule applies to all owners of residential properties which have been used as clandestine drug laboratories; all persons who perform the work of clandestine drug laboratory remediation, including technicians, contractors, training providers, and law enforcement investigating clandestine drug laboratories.

Subsection 2.10 revises the definition of “discrete sample” to require that the individual “100 square centimeters” samples are taken at “individual and specific” locations.

Section 4 of the rule addresses licensed contractor duties. Subdivision 4.1.2. prohibits a contractor from beginning remediation until all required testing has been completed and a Plan Review is submitted. The rule provides that a contractor shall not begin a clandestine drug laboratory remediation project until a preliminary plan is submitted to and a notice to proceed is issued by the department. Subdivision 4.1.6 sets a new timeframe for submission of the final remediation report which is now due within 10 days of receipt of final third-party analytical test results. Under the current rule, this report was previously due based upon completion of remediation as documented on the Plan Review. Section 4.1.7. requires that licensed contractor to supervise demolition of residential property by licensed and certified contractors. Subdivision 4.1.8. is new and requires that the licensed contractor submit all positive analytical test results to the commissioner.

Section 5 addresses licensed technician duties. Subsection 5.3 requires composite sampling for final clearance. Subsection 5.4 has been amended to require that personal property that cannot be remediated be disposed of in accordance with applicable federal, state and local laws. Section 5.5 requires vehicle

testing to be a composite of four discrete samplings and two of which shall be taken as close as possible to the ventilation system.

Section 6 addresses the responsibilities of law enforcement agencies. Subdivision 6.1.3 is new and requires law enforcement to secure the clandestine drug laboratory any controlled substances and immediate precursors from public access. Section 6.1.4 contains new language that requires the vehicle be secured until the initial or post remediation test results are at or below 0.1 µg/100 cm² or the vehicle is demolished.

Section 7 addresses responsibility of residential property owners. The property owner is responsible for ensuring that the property remains unoccupied until testing results indicate a level of contamination at or below 0.1 µg/100 cm² and the property complies with the department's asbestos rule. Subdivision 7.1.3. requires a multi-unit building be secured, vacated, and tested. A new exemption permits adjoining units to remain occupied in a multi-unit building if separated by a fire break wall, pending testing and remediation. Subdivision 7.1.4. has been amended to require a residential property owner whose property has an initial analytical testing of greater than 0.1 µg/100 cm² to engage within 60 days a licensed clandestine drug remediation contractor to either remediate or demolish the residential property. Subsection 7.3. includes new language requiring the residential property owner or his or her agent to disclose information regarding the identification of a clandestine drug laboratory on the residential property to any potential purchaser or occupant.

Section 9 addresses a newly added initial assessment report. Paragraph 9.1.2.e. contains a new requirement that GPS coordinates accompany a physical description of the property. Paragraph 9.1.2.j. has been amended to require that a licensed and certified asbestos inspector verify the presence or absence of asbestos containing materials prior to remediation. The subsection relating to a work plan has been deleted.

Section 10, which is new, addresses the preliminary remediation plan. It requires submission of the plan to the Commissioner and specifies the criteria to be included in the plan including but not limited to a general listing to items to be removed; methods used to wash hard surfaces; the sequence of work activities; items requiring special handling; and asbestos project design; any obvious safety hazards; the methods used to handle cleaning effluents generated during remediation; timeframes; the identification of contractors and subcontractors; and identification of waste disposal sites.

Section 11 addresses the final remediation report. It has been amended to require that copies of asbestos certificates for all asbestos contractors, workers, supervisors, and designers that performed any asbestos remediation and a copy of the final remediation checklist be submitted to the Commissioner.

Section 12 addresses training accreditation. Subsection 12.5 is amended to remove the requirement that a training provider verify that a class participant has completed a training course within the three previous years and replaces it with training within the previous year for both initial training and refresher training. Subsection 12.12 requires that initial training and refresher training be taught independent of one another.

The fee for a technician's license has been raised from \$50 to \$100.

Department of Health and Human Resources – Maternal Risk Screening, 64 CSR 97

The rule amends a current legislative rule which implements the Uniform Maternal Screening Act. Senate Bill 746 which passed during the 2020 Regular Session of the Legislature permitted the

department's contracted managed care companies to be provided Medicaid and CHIP data from the screening tool regarding their own members.

Subsection 6.1 has been amended to state that Medicaid and CHIP member's data may be provided to the Bureau for Medical Services which may provide the data to the patient's contracted care managed care organizations to facilitate case management for at-risk and high-risk pregnancies in a timely manner. Language has also been added regarding the confidentiality of data.

Department of Health and Human Resources – Expedited Partner Therapy, 64 CSR 103

The rule amends a current legislative rule to extend the sunset date to August 1, 2027.

Health Care Authority – Certificate of Need Rule, 65 CSR 32

The rule amends a current legislative rule which implements the provisions of the Certificate of Need (CON) program.

Subsection 4.1 of the rule was amended to reflect that an application received after 4:30 pm, Eastern Standard Time, rather than the existing 5:00 pm Eastern Standard Time, is considered received on the next business day.

Subsection 8.7 states that if an applicant fails to respond to a request for additional information within 45 days, rather than the existing 90 days, the application is considered withdrawn.

Senate Bill 4 which passed during the 2021 Regular Session of the Legislature affecting the appellate and judicial review provisions of this rule. Accordingly, sections 11 and 12 of the rule have been amended to reflect that decisions issued before June 30, 2022, shall be appealed to the Office of Judges. Decisions issued after June 30, 2022, shall be appealed to the West Virginia Intermediate Court of Appeals and be filed with the Clerk of the Supreme Court.

The House amended the rule on page 4, by striking out all of paragraph 2.1.j.9. This amends the definition of "proposed new health service" by removing reference to the expansion of open-heart surgery rooms, cardiac catheterization laboratories, radiation therapy equipment, magnetic resonance equipment (MRI) or PET scanners whether or not the expansion is associated with a capital expenditure.

Department of Health and Human Resources – Medication-Assisted Treatment – Opioid Treatment Programs, 69 CSR 11

The rule extends the sunset date to August 1, 2027.

Department of Health and Human Resources – Syringe Services Program Licensure, 69 CSR 17

The rule is new and establishes standards and procedures for the licensure and regulation of syringe services in the state of West Virginia. This rule applies to any person, partnership, association, or corporation that operates a syringe services program as part of a harm reduction program.

The rule defines terms and sets forth the procedures for the issuance of a license. A license is valid for the location and persons named. Each fixed or mobile site requires a separate license and the license is not transferrable or assignable. The Director or his or her designee may enter the premises of any practice, office, or facility if the Director has reason to believe that it is being operated and maintained without a license.

Any existing syringe services program, as of the effective date of W.Va. Code 16-64-1 which does not offer the full array of harm reduction services must cease and desist from offering all syringe services and operating as a syringe service program. These syringe services programs may continue in operation for the sole purpose of referring current participants to other syringe services programs.

Any new syringe services program shall apply for an initial license not less than 30 days and not more than 60 days before the syringe services program begins operation as part of a harm reduction program. The rule sets forth the contents of the application. An initial license for a syringe services program and renewal licenses are valid for one year. The initial license fee is \$250, and the renewal license fee is \$50.

The rule sets forth circumstances for which a license may be denied and requires the Director shall notify the applicant in writing of the denial and the basis for the decision. Following the denial, the syringe services program must follow closure procedures.

The rule provides for unannounced inspections of a syringe services program for cause if the Director has received a complaint about the program, requires a written report of the results of the investigation, and provides for the correction of deficiencies. The Director may assess a civil monetary penalty, suspend, limit, or revoke a license or take other actions to address any violations or deficiencies. In the event the Director determines that the continued operation of the syringe services program is a threat to health, welfare, and safety of its participant, the Director may issue an order immediately closing a syringe services program pursuant to applicable administrative procedures.

The rule contains provisions regarding emergency planning and response, service environment and operation including a sharps disposal plan, data collection, a community relations program, staff training and credentialing of staff, participant rights, the provision of services, required harm reduction services, and components of a harm reduction program including: HIV, hepatitis, and sexually transmitted diseases screening, vaccinations, birth control and long-term birth control, behavioral health services, overdose prevention supplies and education, syringe collection and sharps disposal, educational services related to disease transmission, assistance or referral of a participant to a substance use disorder treatment program, and referral to a health care practitioner for treatment of medical conditions. The program must have guidelines regarding sharps disposal, staff training, data collection, program evaluation, and community relations.

The rule also has provisions relating to the provision of syringe services, a syringe disposal plan, reports and records, statistical reports and records, incident reporting and adverse events, quality assurance and performance improvement, infection control, license denial, suspension, or revocation, and penalties and equitable relief. The rule states that any person, partnership, association, or corporation that establishes, conducts, manages, or operates a syringe services program without first obtaining a license is subject to a civil monetary penalty. Each day of continuing violation after notification is a separate violation. If the syringe services program fails to timely report, the Director may impose a civil monetary penalty not to exceed \$500 per day. If the syringe services program administrator knowingly and intentionally misrepresents actions taken to correct a violation, the Director may impose a civil monetary penalty not to exceed \$5,000. If an owner of a syringe services program concurrently operates an unlicensed syringe services program, the Director may impose a civil monetary penalty not to exceed \$2,500 per day. If the owner fails to file for a new license upon change of ownership, the Director may impose a civil monetary penalty not to exceed \$2,500. If a syringe services program operates, owns, or manages a syringe services program that is required to be registered and obtains a license through misrepresentation or fraud; procures or attempts to procure a license from any other person by making or causing to be made any false representation, the Director may assess a civil monetary penalty of not more than \$10,000. The rule sets forth the factors for the Director to consider in assessing the fee.

Finally, the rule contains provisions on administrative due process and administrative appeals and judicial review.

Department of Health and Human Resources – All-Payer Claims Database – Data Submission Requirements, 114A CSR 01

The rule amends a current legislative rule and establishes an all-payer claims database for the collection, management, and release of medical claims data submitted by health care payers.

Senate Bill 390 which passed during the 2021 Regular Session of the Legislature and included modifications to the all-payer claims database, including the elimination of the memorandum of understanding process to develop the database. It also provided that the Secretary of DHHR has primary responsibility for the collection, retention, and dissemination of the data in the database. The Insurance Commissioner is charged with enforcement.

The rule requires the Secretary in conformity to develop and maintain an APCD Submission Manual with the National Association for Health Data Organizations. References to previous standards such as “ANSI, ASC, X12, and NCPDP were all removed. The submission manual would be submitted as a procedural rule.

The rule requires the Secretary to inform the insurance commissioner of any health plan that fails to submit data. The rule also requires the Submission Manual to be a legislative rule.

Section 9 is new. It addresses data collection privacy and security requirements. These provisions are included in this rule and the separate rule is being repealed. The transmission from each data submitter must be by a method that prevents unauthorized access and ensures authenticity, confidentiality, and integrity. The transmission must conform to HIPAA and be encrypted. With respect to data retention the data must be retained in a secure manner that prevents unauthorized access and ensures the confidentiality, integrity, and availability of all data and levels required by HIPAA and be encrypted.

Department of Health and Human Resources – All-Payer Claims Database – Privacy and Security Requirements, 114A CSR 02

This rule is being repealed since the provisions of this rule are being incorporated into the previous rule.

CODE REFERENCE: West Virginia Code §64-5-1 et seq. – amended

DATE OF PASSAGE: March 3, 2022

EFFECTIVE DATE: March 3, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4257

Require visitation immediately following a procedure in a health care facility

The bill clarifies that the visitation is permitted once the patient is stable following a surgical procedure. The bill has language that health care facilities shall provide patients have adequate and lawful access to clergy so that patients can practice their religion by receiving clergy visitation at any reasonable time, as long as the visit does not disrupt clinical care; provided that if the health care facility limits the number of people able to visit the patient, the member of the clergy is not to be considered within that number. The bill defines clergy.

CODE REFERENCE: West Virginia Code §16-39-8 and §16-39-3 – amended

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: March 10, 2022

ACTION BY GOVERNOR: Signed March 28, 2022



House Bill 4276

WVU to create a Parkinson's disease registry

The bill permits WVU to collect data on the incident of Parkinson/s disease in WV and other epidemiological data. This registry and system of collection and dissemination of information shall be under WVU. WVU may enter into contracts, grants or other agreements to conduct the program.

All patients diagnosed with Parkinson's disease or related Parkinsonisms shall be provided a notice regarding the collection of information and patient data. Patients who do not wish to participate in the collection of data for purposes of research in this registry shall affirmatively opt-out in writing after an opportunity to review the documents and ask questions.

WVU shall establish a Parkinson's Disease Registry Advisory Committee to assist in the development and implementation of the registry which may include a system for the collection and dissemination of information determining the incidence and prevalence of Parkinson's disease and related Parkinsonisms. The advisory committee shall determine data to be collected and advise WVU. Membership is comprised of various specialty care physicians, neurologists, movement disorder specialists, etc., as set forth in the bill.

A hospital, facility, physician, surgeon, physician assistant, and nurse practitioner, or other health care provider deemed necessary by WVU diagnosing or providing treatment to Parkinson's disease or Parkinsonism patients shall report each case of Parkinson's disease and Parkinsonisms to WVU in a format prescribed by the university.

The bill described permits WVU to enter into data sharing contracts with data reporting entities and their associated electronic medical systems vendors to securely and confidentially receive information related to Parkinson's disease testing, diagnosis, and treatment.

WVU may enter into agreements to furnish data collected in the registry to other state's Parkinson's disease registries, federal Parkinson's disease control agencies, local health officers, or health researcher for the study of Parkinson's disease. Before confidential information is disclosed to those agencies, the requesting entity shall agree in writing to maintain the confidentiality of the information. Additionally, a disclosure authorized by this section shall include only the information necessary for the stated purpose of the requested disclosure, used for the approved purpose, and not further disclosed.

WVU shall maintain an accurate record of all person who are given access to confidential information. The confidential information shall not be available for subpoena, shall not be disclosed, discoverable or compelled to be produced in any civil, criminal, administrative or other civil, criminal, administrative, or other tribunal or court for any reason. This does not prohibit the publication of WVU of reports and statistical compilations that do not in any way identify individual cases or individual sources of information. The bill does not preempt the authority of facilities or individuals providing diagnostic or treatment to services to patients with Parkinson's disease to maintain their own facility-based Parkinson's disease registry.

CODE REFERENCE: West Virginia Code §16-5DD-1 – new

DATE OF PASSAGE: February 15, 2022

EFFECTIVE DATE: February 15, 2022

ACTION BY GOVERNOR: Signed February 23, 2022

House Bill 4288

Relating to expanding the practice of auricular acudetox to professions approved by the acupuncturist board

Auricular acudetox is an acupuncture protocol specifically designed for those struggling with substance abuse issues. Acupuncture needles are placed in the ear at specific points to help the patient. House Bill 4288 permits the West Virginia Acupuncture Board to approve professions other than acupuncturists to engage in the practice of auricular acudetox. The bill also strikes language in current code relating to an applicant being of good moral character and replaces it with a requirement that the applicant be free of a felony conviction bearing a rational nexus to the profession.

CODE REFERENCE: West Virginia Code §30-36-10 – amended

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4324

To update collaborative pharmacy practice agreements

The bill sets forth standards for collaborative pharmacy practice, which is that practice of pharmacist care where one or more pharmacists have jointly agreed, on a voluntary basis, to work in conjunction with one or more physicians under written protocol where the pharmacist may perform certain patient care functions authorized by the physicians under certain specified conditions and limitations.

The bill amends the definition of collaborative pharmacy practice agreement to include a medical provider in training where the agreement is signed by the supervising physician or chairperson of the medical department where the medical provider in training is practicing. The definition strikes approval by the board. A definition is inserted for health care system to mean an organization of people, institutions, and resources that deliver health care services to meet the health care needs of a target population. With respect to pharmacists' scope, board approval is removed. A definition of practice notification is added to mean written notice to the appropriate licensing board that an individual physician or physician group or medical provider in training where the agreement is signed by the supervising physician or chairperson of the medical department where the medical provider in training is located, and an individual pharmacist or pharmacist will practice in collaboration.

With respect to the section regarding practice agreement, it is expanded to include a practice notification. The section provides that a pharmacist or group of pharmacists may practice in collaboration with physicians in any practice setting, including but not limited to a health care setting, pursuant to a practice notification which has been filed with the appropriate board. There is language to grandfather existing agreements. The practice notification is effective immediately upon filing. The boards retain jurisdiction to investigate their respective licensees. The language regarding appeals has been removed.

CODE REFERENCE: §30-5-4 Existing and §30-5-19 Existing

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: March 8, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4333

Relating to the sunset of the Board of Hearing-Aid Dealers and Fitters

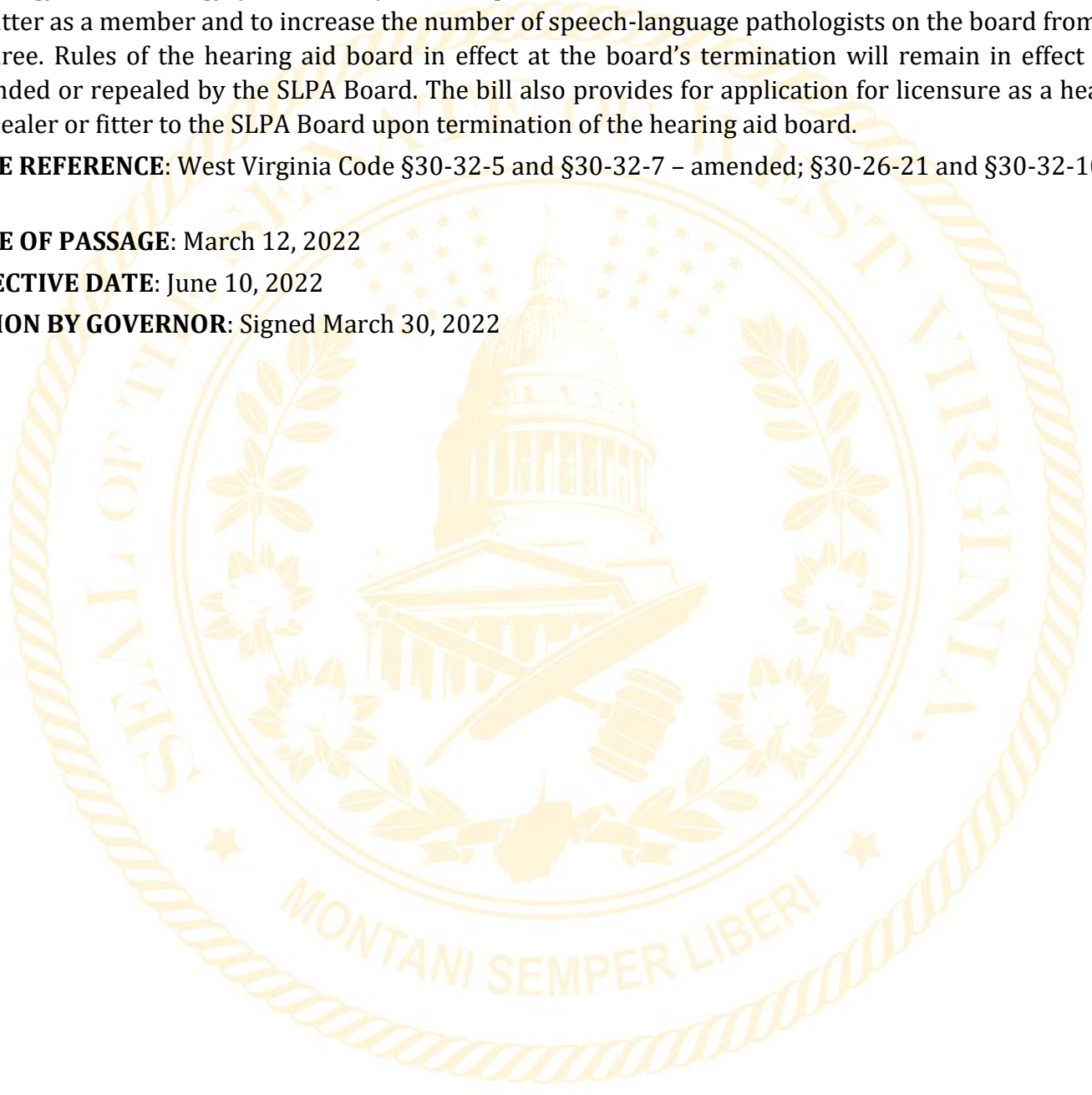
House Bill 4333 sunsets the Board of Hearing-Aid Dealers and Fitters. The board will wind up its business over the next year and terminate effective June 30, 2023. Upon the board's termination, hearing aid dealers and fitters will be regulated and licensed by the Board of Examiners for Speech-Language Pathology and Audiology (SLPA Board). The composition of the SLPA Board will be altered to add a hearing aid fitter as a member and to increase the number of speech-language pathologists on the board from two to three. Rules of the hearing aid board in effect at the board's termination will remain in effect until amended or repealed by the SLPA Board. The bill also provides for application for licensure as a hearing aid dealer or fitter to the SLPA Board upon termination of the hearing aid board.

CODE REFERENCE: West Virginia Code §30-32-5 and §30-32-7 – amended; §30-26-21 and §30-32-10a – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022



House Bill 4340

Relating to maximizing the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education

This bill maximizes the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education. It permits the spouse to consent to organ donation unless spouse and decedent has lived separate and apart from the decedent in the six months prior to the decedent's death or an action for divorce is pending.

The bill provides that an anatomical gift may proceed despite the objection by a member or member of a class.

The bill adds that a person authorized or obligated to dispose of the decedent's body can make an anatomical gift. It also provides that if members of a class disagree regarding the donation, the anatomical gift may proceed despite the objection by a member of the class. Existing law provides for the appointment of a health care surrogate which is deleted.

The bill clarifies the duties of procurement organization with regard to the state medical examiner. It requires the state medical examiner to cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts.

The bill provides that a part may not be removed from the body of a decedent under a medical examiner's jurisdiction for transplantation, therapy, research, or education nor delivered to a person for research or education.

Upon request of a procurement organization, the medical examiner shall release to the procurement organization the name, contact information, name of the next of kin, and available medical and social history of a decedent whose body is under the medical examiner's jurisdiction. If the decedent's body or body part is medically suitable for transplantation, therapy, research, or education, the medical examiner shall release the post-mortem examination results to the procurement organization.

The bill provides that a hospital may not withdraw or withhold any measures necessary to maintain the medical suitability of a body part that may be the subject of an anatomical gift until the organ procurement or designated requestor has had an opportunity to advise the applicable person under this article of the option to make an anatomical gift and has received or been denied authorization to proceed with respect to the body part.

The bill provides that subject to the individual's wishes, after a person's death, persons who may receive the anatomical gift may conduct any test or examination reasonably necessary to evaluate the medical suitability of the body or party for its intended purposes.

There is a section of the bill entitled facilitation of anatomical gift from decedent whose body is under jurisdiction of medical examiner. This section strikes language stating that the medical examiner may not release the body or part of the body that is the subject of an anatomical gift or the social history, medical history with the express authorization of the prosecuting attorney.

Chapter 61 states the chief medical examiner shall cooperate with procurement organizations to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education. The chief medical examiner may enter into contracts and agreements with a procurement organization when necessary to facilitate the efficient and economical recovery of anatomical gifts.

This chapter also provides that the Secretary of Department of Health Human Resources will propose legislative rules for the procedures necessary to maximize the recovery of anatomical gifts for the purpose of transplantation, therapy, research, or education.

CODE REFERENCE: West Virginia Code §16-19-9, §16-19-14, §16-19-22, and §61-12-3 – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022



House Bill 4369

Update the telepsychology compact

The bill updates the telepsychology compact by adding educational criteria for foreign graduates. In order for a foreign graduate to practice telepsychology the foreign graduate must meet the criteria set forth in existing code and hold a graduate degree in psychology that meets the following criteria: the program, wherever it is administratively housed, shall be clearly identified and labeled as a psychology program.

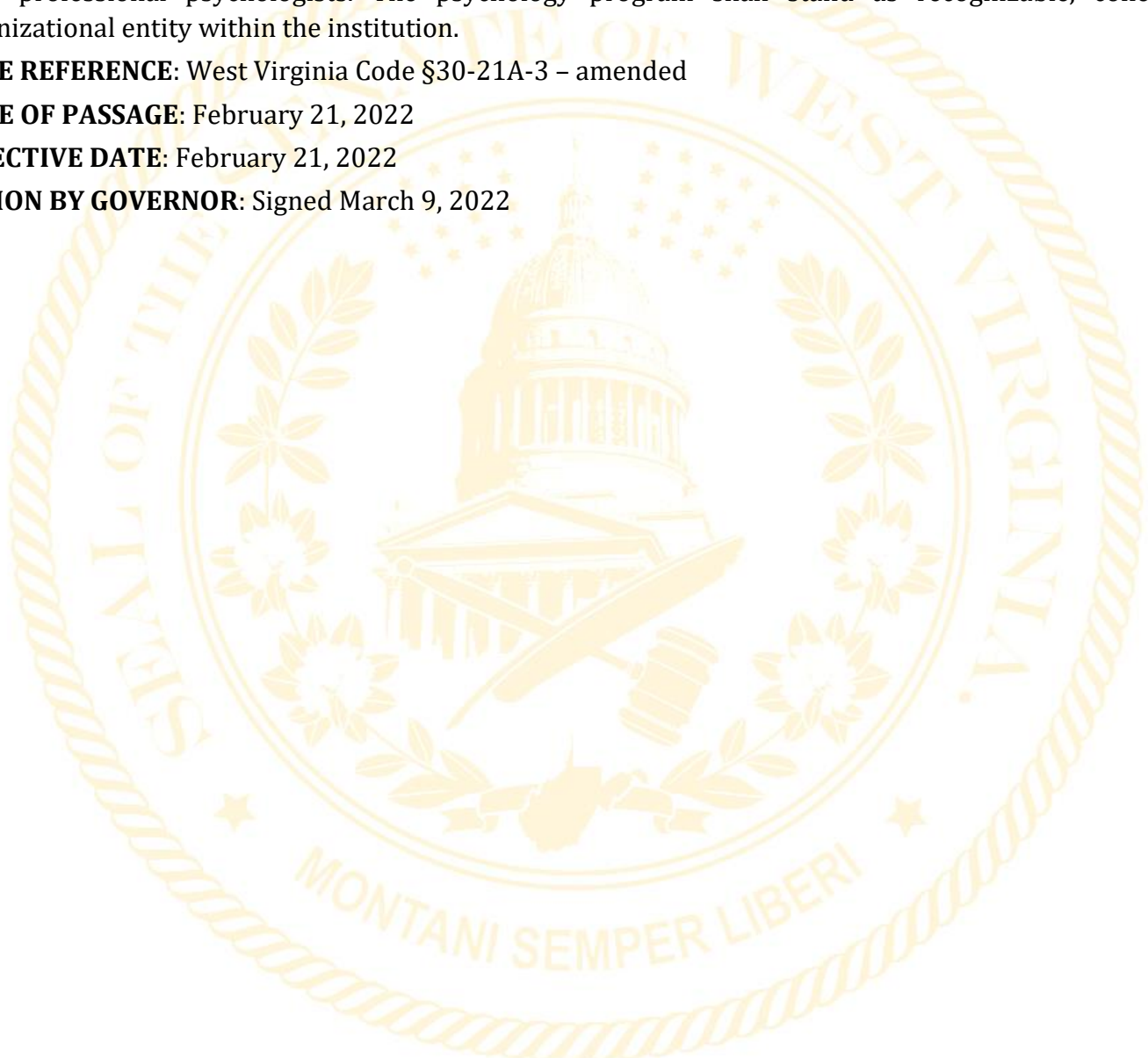
Such program shall specify in pertinent institutional catalogs and brochures its intent to educate and train professional psychologists. The psychology program shall stand as recognizable, coherent, organizational entity within the institution.

CODE REFERENCE: West Virginia Code §30-21A-3 – amended

DATE OF PASSAGE: February 21, 2022

EFFECTIVE DATE: February 21, 2022

ACTION BY GOVERNOR: Signed March 9, 2022



House Bill 4377

To update the involuntary commitment process

The bill makes changes to the involuntary commitment process. A new section of code is added (§27-5-1b) and requires the Secretary of the Department of Health and Human Resources, the Supreme Court of Appeals, the Sheriff's Association, the Prosecuting Attorney's Association, the Public Defender Services, the Behavioral Health Providers' Association, Disability Rights of West Virginia, and the Dangerousness Assessment Advisory Board undertake an evaluation of the utilization of alternative transportation providers and the development of standards that define the role, scope, regulation, and training necessary for the safe and effective utilization of alternative transportation providers. The report shall be presented to the President of the Senate and the Speaker of the House on or before July 31, 2022. The Legislature requests the WV Supreme Court cooperate with the listed parties and undertake this evaluation.

This section also requires the Secretary to establish a process to conduct retrospective quarterly audits of applications and licensed examiner forms prepared by certifiers for the involuntary commitment. This process should determine whether the licensed examiner forms prepared by certifiers are clinically justified and consisted with the requirements of this code.

With respect to the duties of the mental health center, each center shall make available as necessary qualified and competent licensed person to conduct prompt evaluations of persons for commitment. They shall be conducted in person unless it would create a substantial delay, and then the evaluation may be conducted by videoconference.

This section also provides for a pilot program in Cabell, Berkeley, and Ohio counties to implement an involuntary commitment process. It further provides that no alternative transportation provider may be utilized until standards are developed and implemented to define the role, scope, regulation and training necessary for this provider.

The probable cause examination shall be conducted in person unless it would create a substantial delay, and then the evaluation may be conducted by videoconference. The probable cause hearings may be conducted via videoconference unless the individual or his or her attorney object for good cause or unless the magistrate, mental hygiene commissioner or circuit judge order otherwise. The Supreme Court of Appeals is requested to develop regional mental hygiene collaboratives where mental hygiene commissioners can share on-call responsibilities, thereby reducing the burden on individual circuits and commissioners.

The other new section of the bill (§27-5-31) addresses the legal effect of the commitment after it is determined to not be based on mental illness or addiction. This section states that in the event that a person is hospitalized and it is later determined after the entry of the order that the behavior which led to the entry of the order was caused by a physical condition or disorder rather than mental illness or addiction, the hospitalization shall not serve to make him or her a proscribed person under state laws relating to firearms possession or to negatively affect a person's professional licensure, employment, employability or parental rights.

With respect to the certificate filed with the application, it adds a requirement that the certificate include facts that less restrictive interventions and placements were considered but are not appropriate and available. The bill also adds a requirement that the applicant include the names and last known addresses of the persons identified in §27-5-4(e)(3). An exception is added for this process not to apply to competency in criminal proceedings.

With respect to examination of an individual by court-appointed physician, psychologist, advanced nurse or physician assistant, there is an exception when a certificate of the licensed examiner and an application for final civil commitment at the mental health facility where the person is currently committed has been completed and filed.

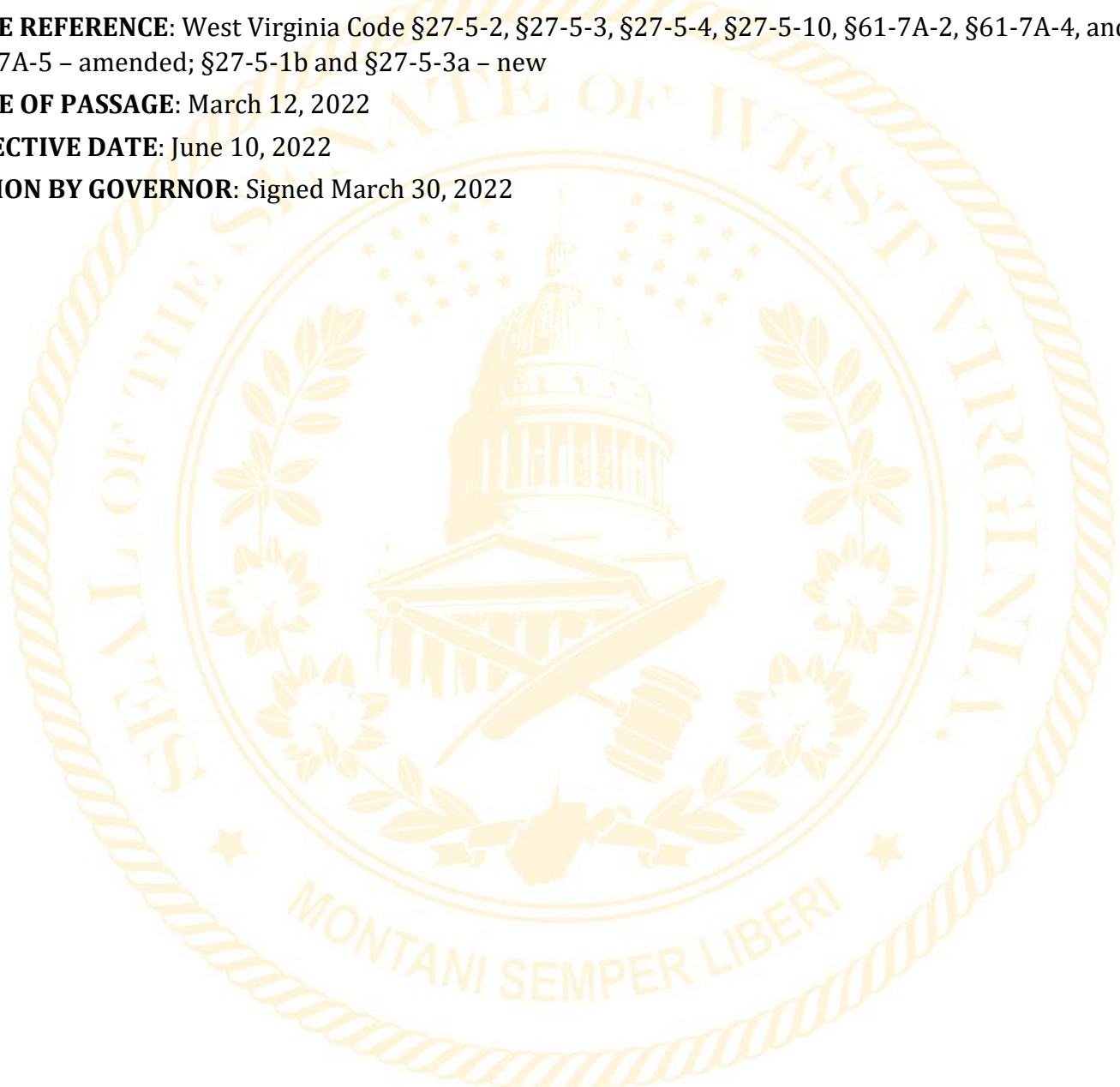
Effective July 1, 2022, the Department of Health and Human Resources shall reimburse the Sheriff, the Department of Corrections and Rehabilitation or other law enforcement agency for the actual costs related to transporting a patient who has been involuntary committed.

CODE REFERENCE: West Virginia Code §27-5-2, §27-5-3, §27-5-4, §27-5-10, §61-7A-2, §61-7A-4, and §61-7A-5 – amended; §27-5-1b and §27-5-3a – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022



House Bill 4393

To increase the managed care tax if the managed care organization receives a rate increase

The bill would amend the section of code that imposes a provider tax on Health Maintenance Organizations (HMOs). In subdivision (d)(i) of the statute, the bill adds the following language: "If the MCO is granted a rate increase the tax shall adjust by the rate of the increase."

The bill has a section that addresses the rate and measure of the tax. It states that prior to July 1, 2022, the tax imposed by this section shall be applied to each taxable health plan's total Medicaid member months within tiers 1, 2, and 3, and to non-Medicaid member months within tiers 4 and 5.

The bill provides that after July 1, 2022, the tax imposed by this section shall be based upon the same tiers 1-5 and for the same member months but for an increased amount of money for tier. Tier 1 is increased from \$35 to \$36.25, Tier 2 is increased from \$20 to \$20.72, Tier 3 is increased from \$1 to 1.036, Tier 4 is increased from 25 cents to 25.9 cents and Tier 5 is increased from 10 cents to 10.36 cents.

The bill provides that on July 1, 2023, and every year thereafter that the tax rates for each tier will be increased by the greater of either 0.0% of the average of the WV Medicaid managed care capitation rate change from the two preceding fiscal years ending on June 30, provided that any increased shall meet the requirements of the federal law related to permissible health care related taxes.

The bill states how the WV Medicaid managed care capitation rate will be calculated. The monthly membership weights by rate cell and month will be determined based on the projected member months from the most recent SFY rate certification. For each of the two preceding fiscal years, to determine the total projection premium payments for each year, the WV Bureau for Medical Services will multiply the initial SFY certified capitation rates net of directed payments by the monthly membership weights by rate cell and month as determined by language set forth earlier in the bill.

For each of the two preceding fiscal years, the WV Bureau for Medical Services will divide the total projected premium payments as set forth above by the total enrollment to determine the average premium payment for each fiscal year.

To determine that average WV Medicaid managed care capitation rate change from the preceding two fiscal years, the WV Bureau for Medical Services will divide the most recent fiscal years average premium payment by the earlier fiscal year's average premium payment and subtract 1.

The bill states that before July 1, 2023 and every July 1 thereafter the WV Bureau for Medical Services will certify to the Tax Commissioner the capitation rate change from the preceding two fiscal years, the calculation used in making the determination and whether the increase meets the requirements of federal and state law for permissible health care related taxes.

The bill requires the WV Bureau for Medical Services and the Tax Commissioner to publish, by Administrative Notice, before July 1 of each year the rate for the next year to each taxable health plan's total Medicaid member month's within Tiers 1, 2, and 3, and to non-Medicaid member months within Tiers 4 and 5.

There are new definitions of tax year which means the fiscal year beginning July 1 and ending on June 30. Rate cell is defined to mean a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment. This would include age, gender, region, etc. Initial SFY rate certification means the MHT and MHP actuarial certifications as submitted to the Centers for Medicare and Medicaid prior to the start of the state fiscal year and prior to any mid-year or other rate amendment.

The bill also extends strikes the termination date for the imposition of this tax.

CODE REFERENCE: West Virginia Code §11-27-10a – amended

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: June 10, 2022

ACTION BY GOVERNOR: Signed March 30, 2022



House Bill 4426

Repeal article 33-25G-1 et seq. creating provider sponsored networks

The bill would repeal articles concerning provider sponsored networks in public health code, §16-2L-1 et seq., and insurance code, §33-25G-1 et seq. Both articles that are being repealed were enacted in 2012.

Provider sponsored networks provide a form of managed health care, currently licensed by the Offices of the Insurance Commissioner (OIC). Insurance code defines “provider sponsored network” as an entity that satisfies the definition of a “Medicaid managed care organization” (MCO) set forth in 42 U.S.C. §1396b(m)(1)(A).

CODE REFERENCE: West Virginia Code §16-2L-1 through §16-2L-7 and §33-25G-1 through §33-25G-5 – repealed

DATE OF PASSAGE: March 7, 2022

EFFECTIVE DATE: June 5, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4559

Providing for legislative rulemaking relating to the disposition of unidentified and unclaimed remains in the possession of the Chief Medical Examiner

House Bill 4559 addresses the problem raised by the Performance Evaluation and Research Division of the Legislative Auditor’s office (PERD) report of November 2021 regarding the storage of human remains at the Office of the Chief Medical Examiner. The report found that the CME’s office lacked appropriate authority for disposition of remains in its possession and that as a result some remains had been stored there since the 1970’s. The focus of the bill is §61-12-15. It provides that the Chief Medical Examiner (CME) shall cremate unclaimed human remains and bury unidentified human remains. The CME, with the assistance of the City of Charleston, is to locate an appropriate cemetery. Unidentified remains are to be buried after six months and after efforts to identify the remains have been exhausted. Remains that have been identified but which have not been claimed shall be cremated after 30 days and after efforts to contact the decedent’s next of kin have been exhausted. The remains shall also be placed in a cemetery in a manner in which the decedent’s remains may be retrieved easily if the next of kin wish to claim the remains.

The bill insulates the CME from liability for actions consistent with the bill.

The bill also requires the CME to propose legislative rules and emergency rules relating to disposition of unidentified and unclaimed remains.

CODE REFERENCE: West Virginia Code §61-12-3, §61-12-5, §61-12-6, §61-12-7, §61-12-10, §61-12-10a, §61-12-11, §61-12-12, §61-12-13, §61-12-14, §61-12-15 – amended; §61-12-16 – new

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: March 30, 2022

House Bill 4570

To allow veterinary telehealth in West Virginia with out of state providers

The bill authorizes out of state veterinarians to offer telehealth services in West Virginia. The bill sets forth the framework to allow the board to authorize telehealth services and clearly defines when telehealth veterinary services are permitted. Any provider offering telehealth services in West Virginia is subject to the jurisdiction of the board. The bill sets the registration fee at \$300 for providers to offer telehealth in this state, renewable annually. Finally, the bill requires all veterinarians meet the same standard of care for telehealth patients as in person visits.

CODE REFERENCE: West Virginia Code §30-10-24 – new

DATE OF PASSAGE: March 10, 2022

EFFECTIVE DATE: June 8, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4631

Establishing a bone marrow and peripheral blood stem donation awareness program

The purpose of the bill is to establish a bone marrow and peripheral blood stem donation awareness program. Directs the Department of Health and Human Services to create a website resource to inform and promote donation awareness. Provides contents for an electronic brochure and website. Provides for consultation with health care providers to promote awareness of the federal and any state resources available for donations.

CODE REFERENCE: West Virginia Code §16-21-2 – new

DATE OF PASSAGE: March 7, 2022

EFFECTIVE DATE: June 5, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4634

Relating to occupational licensing or other authorization to practice

House Bill 4634 permits recognition of an individual's occupational license in another state for licensure in this state. The bill requires a person with a license in another state apply for licensure in this state to the board or similar entity that regulates the profession in this state.

The bill sets forth criteria that a person applying for licensure in this state must meet:

- the person holds a valid license from another state;
- the person has held the license for at least one year;
- the person meets all education and examination requirements in the state where he or she is currently licensed;
- the person is a WV resident;
- boards in every state where the person is licensed hold the person in good standing;
- the person doesn't have a disqualifying criminal record;
- the person has never had their license revoked;
- the person has never surrendered a license;
- the person has no pending complaints, allegations, or investigations pending; and
- the person pays all applicable fees in this state.

The bill also sets forth criteria allowing a board to issue an occupational license in this state to a person based on his or her work experience:

- The person worked in a state that does not license the profession;
- The person has worked for at least two years in the occupation;
- The person has taken and passed any national examinations to practice; and
- The person satisfies requirements 6 - 10 stated above.

The bill permits a state board to require a person to take a jurisprudential examination for a license if the board requires the same of all other applicants. The bill allows a board 60 days to make a decision on a completed application. The bill provides an appeal process for a person to appeal to court the board's decisions regarding licensure, scope of practice, or other authorization. The bill stipulates that licensure in this state does not entitle a person to practice in another state unless otherwise provided for by interstate compact or other agreement. The bill permits the board to charge a limited fee for such application. Finally, the bill preempts any other law or ordinance by township, municipality, county, or other governments from requiring an additional license to practice.

CODE REFERENCE: West Virginia Code §21-17-1 through §21-17-12 and §29-33-1 through §29-33-12 – new

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4647

Relating to the Board of Funeral Service Examiners

House Bill 4647 updates code concerning Funeral Service Examiner board licensure requirements. The bill updates the reference to the specific examination the board administers to one through the International Conference of Funeral Service Examining Boards and clarifies that the state jurisprudential examination will be administered through the International Conference of Funeral Service Examining Boards. The bill also clarifies that the apprentice program may be completed before, during, or after formal education and specifies additional requirements necessary to obtain a license, such as directing at least 35 funerals or memorials.

The bill removes the requirement that the board provide continuing education but does not alter or remove continuing education requirements for licensees. Continuing education may be obtained from other sources than the board. The bill establishes a biennial inspection process for funeral establishments and creates a new section to permit the use of alkaline hydrolysis as a means of final disposition of human remains when certified by the board.

CODE REFERENCE: West Virginia Code §30-6-3, §30-6-8, §30-6-9, §30-6-15, §30-6-16, §30-6-17, §30-6-19, §30-6-20 – amended; §30-6-22b – new

DATE OF PASSAGE: March 9, 2022

EFFECTIVE DATE: June 7, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4649

Transferring the operations of the West Virginia Children's Health Insurance Program to the Bureau for Medical Services

The purpose of the bill is to transfer the operations of the West Virginia Children's Health Insurance Program to the Bureau for Medical Services and delegate policymaking authority from the current board of directors to the program director.

The bill deletes references to the Department of Administration and the transfer of the program from the Department of Administration to the Department Health and Human Resources. This transfer occurred several years ago.

The bill transfers the program within DHHR to the Bureau of Medical Services (BMS) within the Department of Health and Human Resources and makes it a division within BMS.

The functions of the board are transferred to the director. The director is a new position and is a deputy commissioner within the Bureau for Medical Services who has responsibility for the operation and oversight of the Children's Health Insurance Plan (CHIP).

The CHIP board is changed to an advisory board. The advice and consent of the Senate is removed from board member appointment since the board is now an advisory board. Members of the House of Delegates are ex officio members. The citizen members are removed. Provisions related to removal by the Governor are removed. The new purpose of the board is to present recommendations and alternatives for the design of the annual plans and to advise the director with respect to other actions necessary to be undertaken in furtherance of this article. The previous function of the board was to develop plans for health services or health insurance that are specific to the needs of children and to bring fiscal stability to this program through development of an annual financial plan. Other provisions are deleted regarding board meetings. Now, the board will meet at the call of the chair. The bill provides that each member of the advisory board shall receive reimbursement for reasonable and necessary travel expenses for each day actually serviced in attendance at meetings of the board.

With respect to assignment of rights the DHHR adds language clarifying how subrogation will work on behalf of the department if medical assistance is paid to a provider of medical care on behalf of CHIP recipient and another person is legally liable for the expense pursuant to negligence or otherwise.

CODE REFERENCE: West Virginia Code §5-16B-6b, §5-16B-6c, and §5-16B-6e – repealed; §5-16-1, §5-16B-2, §5-16B-3, §5-16B-4, §5-16B-5, §5-16B-6, §5-16B-6a, §5-16B-6d, §5-16B-8, §5-16B-9, §5-16B-10 – amended

DATE OF PASSAGE: March 8, 2022

EFFECTIVE DATE: June 6, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

House Bill 4662

Relating to licensure of Head Start facilities in this state

The bill provides that a head start program in good standing with the US Department of Health and Human Services may request to be deemed licensee to operate a child care program to purposes of the WV Clearance for Access Registry and Employment Screening. The bill provides that at the discretion of the Secretary, a deemed license may not permit the licensee to access the other services provided by the Bureau for Family Services as it related to the specific deemed child care license.

The bill provides for legislative rulemaking.

CODE REFERENCE: West Virginia Code §49-2-115a – new

DATE OF PASSAGE: March 12, 2022

EFFECTIVE DATE: March 12, 2022

ACTION BY GOVERNOR: Signed March 30, 2022

House Bill 4743

Relating to security and surveillance requirements of medical cannabis organization facilities

The bill adds language to existing law regarding medical cannabis organizations requirements to implement and maintain security, tracking, recordkeeping and surveillance systems related to the medical cannabis. The bill would add a proviso to the existing language that states the bureau may require that a medical cannabis organization maintain motion activated surveillance at a dispensary, grower, or processor facility and that a medical cannabis organization retain the recordings therefrom onsite or offsite for a period not to exceed 180 days, unless required for investigative or litigation purposes.

CODE REFERENCE: West Virginia Code §16A-6-3 – amended

DATE OF PASSAGE: March 11, 2022

EFFECTIVE DATE: June 9, 2022

ACTION BY GOVERNOR: Signed March 28, 2022

2022 Second Extraordinary Session

House Bill 214

Relating to prescriptive authority

The purpose of this bill is to clean up the code concerning prescriptive authority of advance practice registered nurses by removing the prescriptive authority from §30-3E-3 and reapplying it in §30-7-15a. Additionally, the bill makes changes to rulemaking for both physician assistants and registered professional nurses. While the bill leaves intact the WV Board of Medicine's ability to propose rules regarding the eligibility and extent to which a physician assistant may prescribe, it strikes specific detail regarding prescriptive authority for physician assistants. With respect to the WV Board of Examiners for Registered Professional Nurses, the rulemaking language is removed. Now, the proposed legislation states that a physician assistant and advance practice registered nurse may not prescribe a schedule I controlled substance, prescribe up to a 3-day supply of a schedule II narcotic, and there are no other limitations on a physician assistant's advance practice registered nurse or prescribing authority, except as provided in the opioid reduction act. The Senate Committee on Health and the Judiciary Committee recommended passage of HB 4111.

CODE REFERENCE: West Virginia Code §30-3E-3 and §30-7-15a – amended

DATE OF PASSAGE: April 27, 2022

EFFECTIVE DATE: April 27, 2022

ACTION BY GOVERNOR: Signed May 3, 2022

2021 Regular Session



Senate Bill 12

Relating to local health department accountability

The bill creates a definition of appointing authority that includes the county commission or municipality or combination thereof that authorized the creation of the local board of health.

The bill permits a member of the appointing authority to remove a member of the local board of health. The reasons permitted for removal are listed and include: official misconduct, incompetence, neglect of duty, or the revocation of any state professional license or certification. Gross immorality was removed as a basis for removal. Language was added to address a combined board. This section states with respect to a combined board, a county commission or appointing authority may remove any of its appointed members pursuant to the provisions of its lawfully adopted bylaws and shall remove any of its appointed members for official misconduct, incompetence, neglect of duty, or the revocation of any state professional license or certification.

Existing language permitted a local board of health to adopt, promulgate, and amend rules and file the rule with the clerk of the county commission. The bill adds language to require the commissioner to establish a procedure by which adverse determinations by local health departments may be appealed, unless otherwise provides for, for the purpose of ensuring a consistent interpretation of state public health laws and rules of the Department of Health and Human Resources.

The bill provides that when rule is adopted, promulgated, or amended, the local board of health shall place a notice in the State Register and on their organization's web page, setting forth a notice of proposed action, including the text of the new rule or amendment, and the date, time, and place for receipt of public comment;

The bill provides all rules shall be approved, disapproved, or amended and approved by the county commission or appointing entity within 30 days of approval from the local health department. All rules of a combined local board of health shall be approved, disapproved, or amended and approved by each appointing entity within 30 days of approval from the combined local board of health. If one appointing entity approved and another does not approve a rule from a combined local board health department, the rule is only in effect in the jurisdiction of the appointing entity which approved the rule;

An approved rule shall be filed with the clerk of the county commission or the clerk or the recorder of the municipality, or both, and shall be kept by the clerk or recording officer in a separate book as public records. The bill provides a rule currently in effect is not subject to approval, unless amended, from the county commission or appointing authority;

The bill provides if there is an imminent public health emergency, approval of the county commission or appointing authority is not necessary before the rule goes into effect but shall be approved or disapproved by the county commission or appointing authority within 30 days after the rules are effective.

Finally, the bill provides that if the Governor declares a statewide public health emergency, the state health officer may develop emergency policies and guidelines that each of the local health departments responding to the emergency must comply with in response to the public health emergency.

CODE REFERENCE: West Virginia Code §16-2-2, §16-2-9, §16-2-11 – amended

DATE OF PASSAGE: March 4, 2021

EFFECTIVE DATE: June 2, 2021

ACTION BY GOVERNOR: Signed March 16, 2021

Senate Bill 67

Relating to authority of Emergency Medical Services Advisory Council

The bill requires that Emergency Medical Services Advisory Council to review any rule proposed by the Bureau for Public Health Commissioner for legislative approval and provide a recommendation to the Legislative Rule Making Review Committee. The proposed recommended actions include that the Legislature: authorize the rule, authorize part of the rule, authorize the rule with amendments, recommend the rule be withdrawn, or reject the rule.

CODE REFERENCE: West Virginia Code §16-4C-5 – amended

DATE OF PASSAGE: March 26, 2021

EFFECTIVE DATE: March 26, 2021

ACTION BY GOVERNOR: Approved by the Governor on April 7, 2021



Senate Bill 160

Authorizing Department of Revenue to promulgate legislative rules

This is a Department of Revenue rules bundle containing 16 rules. Only the legislative rules directly relating to the health care industry are included in this summary.

Insurance Commission – Insurance Adjusters, 114 CSR 25

This rule amends a current legislative rule and pertains to the licensing and regulation of insurance adjusters. The rule amends an existing rule to make changes necessitated by the passage of House Bill 4502 during the 2020 Regular Session of the Legislature. That bill updated and rewrote the article in the insurance code on insurance adjusters. The rule modifies licensure requirements to allow for three nationally recognized types of adjuster (independent, company, and public adjusters). West Virginia did not have a license for independent adjusters until the passage of House Bill 4502. The need for the additional type of adjusters was to eliminate the negative affects to reciprocity for West Virginia resident adjusters with the many states who license independent adjusters separately. Consistent with the statute, the rule also exempts from the public adjuster licensure requirement various groups and people, including attorneys and claim investigators and exempts from the independent adjuster and company adjuster's licensure requirement various groups and people, including attorneys and persons who negotiate or settle claims under life or health insurance policies.

The National Association of Insurance Commissioners' (NAIC) "Public Adjusters Licensing Model Act (Model 228) amended provisions regarding an emergency adjuster license. This license allows adjusters not licensed in this state to receive an emergency license in cases of insurance emergencies. The rule sets out certain information which is required to be provided to the Insurance Commissioner to allow them to receive an emergency license.

The rule also adds language regarding adjuster's lines of authority that mirrors the statutory provisions. The portion of the rule that sets out the qualifications required for resident adjuster's licenses has been modified slightly to reflect changes to the statute.

Insurance Commission – Credit for Reinsurance, 114 CSR 40

This rule amends a current legislative rule. The changes are necessary to incorporate changes made to the West Virginia Code by the passage of House Bill 4146 during the 2020 Regular Session of the Legislature needed for the West Virginia Offices of the Insurance Commissioner (OIC) to remain accredited. The bill added language to West Virginia's credit for reinsurance code from the National Association of Insurance Commissioners (NAIC) Model, Credit for Reinsurance Model Law (Summer 2019), Model No. 785. The language expanded the group of assuming insurers to which reinsurance may be ceded.

The purpose of the rule is to regulate reinsurance described by NAIC as insurance of insurance companies. It is an indemnity between a reinsurer and an insurer, and it operates as a transfer of risk from an insurer (the cedent) to the reinsurance company which contractually assumes all or part of the risk of one or more insurance policies issued by the insurance company. This is an essential part of the insurance industry to manage risks.

The rule incorporates the provisions of West Virginia Code §33-4-15a. It requires assuming insurers have their head office or be domiciled in a reciprocal jurisdiction and defines "reciprocal jurisdiction." It specifies assuming insurers' minimum capital and surplus requirements and minimum solvency or capital ratios. The rule further requires assuming insurers to inform the Insurance Commissioner if such minimum requirements are no longer met. Assuming insurers would have to consent to the jurisdiction of courts in

West Virginia, agree to the OIC as agent for service of process, and would be bound to pay any final judgments.

In addition to the list of reciprocal jurisdictions published by NAIC, the OIC would be required to publish a list. The rule incorporates statutory provisions which provide when the OIC may add or subtract a jurisdiction from the list in specified circumstances. The OIC would also be required to publish a list of assuming insurers that have met all requirements. If an assuming insurer's eligibility is suspended, a reinsurance agreement with it would not qualify for credit. Likewise, the rule adopts statutory provisions which provide that if an assuming insurer's eligibility is revoked, no reinsurance credit would be granted.

Insurance Commission – Continuing Education for Individual Producers and Individual Insurance Adjusters, 114 CSR 42

The current rule provides the requirements for continuing education for insurance producers. The rule provides that individual insurance adjusters are subject to the same continuing education requirements as the producers. This change incorporates the statutory changes adopted pursuant to House Bill 4502 passed during the 2020 Regular Session of the Legislature. Consistent with the authorizing statute, the rule requires the Board of Insurance Agent Education to develop the continuing education program which is submitted to the Insurance Commission. The continuing education requirements are biennial and are effective with the reporting period beginning July 1, 2021.

Insurance Commission – Mental Health Parity, 114 CSR 64

This rule is a repeal and replace of a current legislative rule. The rule establishes procedures and requirements to ensure mental health parity among the various types of insurance plans offered in West Virginia. The changes were necessitated by the passage of Senate Bill 291 during the 2020 Regular Session of the Legislature.

The rule defines key terms including the term behavioral, mental health and substance use disorder. The provisions of 45 CFR 146(c) are incorporated by reference.

The rule provides for the required coverage for mental health services including substance use disorders. The coverage applies to the Public Employees Insurance Agency (PEIA) and all other types of enumerated insurance carriers. All carriers are required to:

- Include coverage for behavioral health screenings with coverage and reimbursement no less extensive than coverage and reimbursement for the annual physical examination;
- Comply with nonquantitative treatment limitations requirements specified in federal regulations. It precludes PEIA and the carriers from applying nonquantitative treatment limitations to behavioral health, mental health or substance use disorder that do not apply to medical and surgical benefits;
- Comply with financial requirements and quantitative treatment limitations in federal regulations. It precludes carriers from applying quantitative limitations to behavioral health, mental health or substance use disorder that do not apply to medical and surgical benefits;
- Establish procedures to authorize treatment with a nonparticipating provider if a service is not available-network adequacy issues; and
- Authorize payment at the same rate used to pay for medical and surgical benefits.

A carrier may not apply any nonquantitative treatment limitations to benefits to behavioral health, mental health, and substance abuse that are not applied to medical and surgical benefits within the same class of benefits.

The rule sets forth the process for denial and provides that, unless the claim is denied for nonpayment of premium, a denial for reimbursement for the prevention of, screening for, or treatment of behavioral, mental health or substance use disorder by PEIA and the insurance carriers must contain specified language.

Consistent with the provisions of the authorizing statute, the rule requires the Insurance Commissioner submit an annual parity report to the Joint Committee on Government and Finance. The first report will be submitted by June 21, 2021 and submitted annually thereafter. The report contains data to demonstrate parity compliance, medical necessity criteria used in determining benefits for behavioral health, mental health, and substance use disorder and the medical necessity in determining medical and surgical benefits. The report will also include identification of all nonquantitative treatment limitations that are applied to benefits for behavioral, mental health, and substance use disorder and to medical and surgical benefits within each classification of benefits.

Insurance Commission – Health Benefit Plan Network Access and Adequacy, 114 CSR 100

This new rule implements the Health Benefit Plan Network Access and Adequacy Act, House Bill 4061, passed during the 2020 Legislative Session. The legislation requires a health insurer that maintains a network of health care providers for its insureds to ensure that the network is sufficient in numbers and has appropriate types of providers in order for all covered services to be accessible without unreasonable travel or delay.

The rule sets forth network access plan standards, processing services or other prescription drug or device services, or both, for health benefit plans. This rule was filed pursuant to the passage of Senate Bill 489 during the 2019 Regular Legislative Session.

CODE REFERENCE: West Virginia Code §64-7-1 et. seq. – amended

DATE OF PASSAGE: March 23, 2021

EFFECTIVE DATE: March 23, 2021

ACTION BY GOVERNOR: Signed March 31, 2021

Senate Bill 182

Authorizing miscellaneous agencies and boards to promulgate legislative rules

This Miscellaneous Rules Bundle 9 contains 34 rules. Only the legislative rules directly relating to the health care industry are included in this summary.

Hearing Aid Dealers - Rules Governing the West Virginia Board of Hearing Aid Dealers, 8 CSR 1

This rule increases license application fee, license renewal fee, trainee permit application fee, and trainee permit renewal fee for hearing aid fitters and dealers from \$100.00 (current) to \$120.00; adds late renewal fees; and updates the Board of Hearing Aid Dealers' address for advertising.

Board of Medicine - Registration to Practice During Declared State of Emergency, 11 CSR 14

This new rule establishes a registration process to practice during a declared state of emergency. The rule establishes a registration process, sets forth eligibility criteria, and permits practice of registrants during a declared emergency. This allows physicians and Physicians Assistants (PA) licensed in another state to provide medical care in West Virginia under special provisions during the period of a declared state of emergency and allows physicians and PAs who hold and inactive or expired licensed to provide care during an emergency.

Board of Occupational Therapy - Telehealth Practice: Requirements, Definitions, 13 CSR 9

The purpose of this new rule is to establish procedures for the practice of telehealth by a licensed occupational therapist or occupational therapy assistant.

Practitioner-patient relationships must be initially established by interactive audio store-forward technology, real-time videoconferencing, or similar secure video services. Audio-only or written forms of communication are not permitted to establish the practitioner-patient relationship, however, once the relationship has been established the use of any telehealth technology that meets the standard of care may be used.

Prior to providing occupational therapy services via telehealth, the therapist must determine whether an in-person appointment is necessary and make every attempt to ensure that a therapist is available if an on-site visit is required, and that the therapist and/or therapy assistant will provide the appropriate interventions. Occupational personnel must obtain informed consent for the telehealth appointment from the patient prior to the initiation of these services, maintain documentation of the consent-to-treat process, and keep these records within the patient's health records.

The same standard of care must be exercised by the occupational therapists and assistant as all other mode of service delivery. Confidentiality of medical information must be secured and maintained as required by HIPAA and state and federal law. Assistants working under general supervision can provide services via telehealth. Telehealth cannot be used when direct supervision is required. All supervision requirements must be followed.

Board of Osteopathic Medicine - Licensing Procedures for Osteopathic Physicians, 24 CSR 1

This rule amends a current legislative rule which establishes the operation of the Osteopathic Board and the regulation and licensing of osteopathic physicians.

The amendments to this rule are required as a result of the passage Senate Bill 770 during the 2020 Regular Session of the Legislature. With respect to the issuance of a license (subdivision 4.2.c) the rule strikes language requiring an applicant for license to practice osteopathic medicine to include evidence of the completion of one year of clinical training under one of two options. In lieu of this language, the rule

inserts a requirement for evidence of the completion of a minimum of one year of post-doctoral clinical training in a program approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education.

The qualifications for the issuance of a license to practice by reciprocal endorsement has been similarly amended to also require the successful completion of a minimum of one year of post-doctoral training in a program approved by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education. This section also adds language requiring an applicant to submit to a state and national background check similar to a licensee.

With respect to the temporary permit to practice osteopathic medicine, the rule requires the same post-doctoral training and inserts language requiring an applicant to submit to a state and national criminal background check.

Board of Osteopathic Medicine - Emergency Temporary Permits to Practice During States of Emergency or States of Preparedness, 24 CSR 9

This new rule establishes a registration process to practice during a declared state of emergency, sets forth eligibility criteria, and permits practice of registrants during a declared emergency. This will allow physicians and PAs licensed in another state to provide medical care in West Virginia under special provisions during the period of a declared state of emergency; and to allow physicians and PAs who hold and inactive or expired licensed to provide care during an emergency.

Board of Pharmacy - Licensure and Practice of Pharmacy, 15 CSR 1

The rule amends a current legislative rule. The definition of the term "compounding" has been amended to specify those processes which are not included within the definition. These include: tablet splitting; capsule opening; adding nonallergenic flavoring; and combining commercially manufactured products. The term "electronic supervision" is also defined. Section 14, relating to the sanitary regulation of pharmacies has been completely rewritten.

Board of Pharmacy - Uniform Controlled Substances Act, 15 CSR 2

The rule updates the reference to Drug Enforcement Administration (DEA) regulations to 2020. The provisions of Subsection 8.15 which relate to the refilling of Schedule III and Schedule IV prescriptions has been amended to also apply to Schedule V prescriptions.

Board of Pharmacy - Board of Pharmacy Rules for Continuing Education for Licensure of Pharmacists, 15 CSR 3

This rule updates continuing education requirements for licensed pharmacists and pharmacy technicians. House Bill 4417 passed during the 2020 Regular Legislative Session permits different types of continuing education (CEs) to qualify for completion of the drug diversion continuing education requirements, best-practice prescribing of controlled substances training and training on prescribing and administration of an opioid antagonist as approved by each professions' licensing board. The Board of Pharmacy lowered the required CEs related to drug diversion training and best practice prescribing of controlled substances from three hours to two hours. The specific requirements of the training have been removed giving the licensees more flexibility in how to obtain the continuing education. In addition, the proposed rule updates the definition of "CPE hour" to permit the acceptance of 15 minute intervals which would count as .25 credit hours; provides that ACPE approved providers do not need to give a statement of credit to pharmacists; provides that the Continuing Pharmacy Education Committee will approve non-accredited ACPE continuing education; deletes section relating to Board approval of providers; states that

all activities by ACPE accredited providers are approved continuing education; and removes the specific subjects for continuing education.

Board of Pharmacy - Licensure of Wholesale Drug Distributors, Third Party Logistics Providers and Manufacturers, 15 CSR 5

This rule requires a wholesale distributor who is disciplined in another state to inform the Board of Pharmacy within 30 days after entry of the final order. It also requires a wholesale distributor to submit a list directors and officers at the time of licensure and licensure renewal.

Board of Pharmacy - Controlled Substances Monitoring Program, 15CSR 8

This rule adds schedule V drugs to the schedules of drugs be reported to Monitoring Program and the section relating to confidentiality. The current rule establishes requirements for the recordation and retention in a single repository of information regarding the prescribing, dispensing, and consumption of certain controlled substances, "drugs of concern", and opioid antagonists; this section has been deleted as there are no longer any drugs of concern.

Board of Pharmacy - Immunizations Administered by Pharmacists and Pharmacy Interns, 15 CSR 12

This rule has been updated pursuant to Senate Bill 544 which passed during the 2020 Regular Legislative Session and gave pharmacists the ability to provide all Centers for Disease Control recommended immunizations. Section 13 has been amended to read as follows:

§15-12-3. Immunizations.

A licensed pharmacist or pharmacy intern may administer immunizations in accordance with definitive treatment guidelines for immunizations promulgated by the latest notice from the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), including, but not limited to, the CDC's recommended immunization schedule for adults, children, and adolescents.

A licensed pharmacist or pharmacy intern may administer immunizations in accordance with definitive treatment guidelines for immunizations promulgated by the latest notice from the CDC, including, but not limited to, the CDC's recommended immunization schedule for adults, children and adolescents to a person aged 11 through 17, with written informed parental consent when presented with a prescription from a physician and there are no contraindications to that patient receiving that vaccine.

Board of Physical Therapy - General Provisions for Physical Therapist and Physical Therapist Assistants, 16 CSR 1

The rule has been amended as follows:

- Adds new terms and defines "dry needling", "originating site and "telehealth services";
- Expands manual therapy techniques under scope of practice to include without limitation dry needling;
- Incorporates telehealth into requirements for supervision of physical therapist assistants;
- Adds Board of Certification as automatically approved continuing education provider; and
- Adds new section 12 setting forth requirements for telehealth practice including required elements under W. Va. Code §30-1-26.

Board of Physical Therapy - Fees for Physical Therapist and Physical Therapist Assistants, 16 CSR 4

The rule removes the flat \$50 fee for continuing education course providers and replaces it with a dual-fee structure for continuing education course providers of \$25 for a course up to nine hours and \$50 for a ten hour or longer course.

Board of Physical Therapy - General Provisions for Athletic Trainers, 16 CSR 5

This rule has been amended as follows:

- Adds new terms and defines "dry needling", "originating site and "telehealth services";
- Adds CAATE College/University as automatically approved continuing education provider;
- Adds new section 12 setting forth requirements for dry needling; and
- Adds new section 13 setting forth requirements for telehealth practice including required elements under W. Va. Code §30-1-26.

Board of Physical Therapy - Fees for Athletic Trainers, 16 CSR 6

The rule removes the flat \$50 fee for continuing education course providers and replaces it with a dual-fee structure for continuing education course providers of \$25 for a course of up to nine hours and \$50 for a ten hour or longer course. The rule also adds an athletic trainer delinquent license fee of \$210 and a continuing education non-compliance fee of \$200.

Board of Respiratory Care - Criteria for Licensure, 30 CSR 1

This new rule establishes the criteria for licensure by the Board of Respiratory Care. Respiratory educational programs are going to a four-year bachelor's degree and will no longer offer a two-year Associate degree. The rule provides that upon payment of required fees, an applicant for licensure to practice respiratory care shall submit to the board, via official written oath, evidence that the applicant has completed a board approved respiratory care educational program; on or after July 1, 2022, holds a current valid registered respiratory therapist credential from the National Board of Respiratory Care; prior to July 1, 2022, the applicant holds a current valid Certified Respiratory Therapist or Registered credential from the National Board of Respiratory Care or its successor and has successfully passed an exam administered by the state or a national agency approved by the Board. The rule provides that the Board may issue a license by endorsement and provides criteria for reinstatement of a license.

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: March 25, 2021

EFFECTIVE DATE: March 25, 2021

ACTION BY GOVERNOR: Signed March 31, 2021

Senate Bill 277

Creating COVID-19 Jobs Protection Act

This bill prohibits civil actions for any loss, damages, personal injury, or death arising from COVID-19 against any individual or entity, including health care providers, institutions of higher education, businesses, manufacturers, and volunteers. “Arising from COVID-19” includes, but is not limited to:

- Implementing policies and procedures designed to prevent or minimize the spread of COVID-19;
- Testing; and/or monitoring, collecting, reporting, tracking, tracing, disclosing, or investigating COVID-19 exposure or other COVID-19 related information;
- Using, designing, manufacturing, providing, donating, or servicing precautionary, diagnostic, collection, or other health equipment or supplies, such as personal protective equipment;
- Closing or partially closing to prevent or minimize the spread of COVID-19;
- Delaying or modifying the schedule or performance of any medical procedure;
- Providing services or products in response to government appeal or repurposing operations to address an urgent need for personal protective equipment, sanitation products, or other products necessary to protect the public;
- Providing services or products as an essential business, health care facility, health care provider, first responder, or institution of higher education; and actions taken in response to federal, state, or local orders, recommendations, or guidelines lawfully set forth in response to COVID-19.

This bill expressly does not preclude an employee from filing a claim for workers’ compensation benefits. It also does not preclude certain types of product liability claims or claims against any person who engaged in intentional conduct with actual malice.

CODE REFERENCE: West Virginia Code §55-19-1, §55-19-2, §55-19-3, §55-19-4, §55-19-5, §55-19-6, §55-19-7, §55-19-8, and §55-19-9 – new

DATE OF PASSAGE: March 11, 2021

EFFECTIVE DATE: March 11, 2021; retroactive to January 1, 2020

ACTION BY GOVERNOR: Signed March 19, 2021

Senate Bill 334

Establishing license application process for needle exchange programs

The bill creates a licensure program for a syringe services program. The first section of the bill addresses definitions. Harm reduction means a program that provides services intended to lessen the adverse consequences of drug use and protect the public health and safety, by providing direct access to or a referral to: syringe services program, substance use disorder treatment programs, screenings, vaccinations, education about overdose prevention, wound care, opioid antagonist distribution and education, and other medical services. A syringe services program is defined as a community-based program that provides access to sterile syringes, facilitates safe disposal of used syringes, and is part of a harm reduction program. A syringe is defined as both the needle and the syringe used to inject fluids into the body.

With respect to licensure, the bill provides that all new and existing programs shall obtain a licensure from the Office for Health Facility Licensure and Certification and sets forth the criteria for the application. This section includes general application information, including but not limited to the name of the applicant, a description of the services to be provided, contact person, hours of operation, description of the applicant's ability to encourage usage of medical care and mental health services as well as social welfare and health promotion, letters of support from a majority of the members of the county commission and a majority of the members of a governing body of the municipality in which it is proposing to locate, and the payment of a fee.

The bill sets forth program requirements. The bill states that to be approved for a license, a syringe services program shall be part of a harm reduction program which offers or refers an individual for services. The services include the following: HIV, hepatitis and sexually transmitted diseases screening; Vaccinations, birth control and long-term birth control, behavioral health services, overdose prevention services, syringe collection and sharps disposal, educational services related to disease transmission, assist or refer and individual to substance use treatment program, refer to a health care practitioner or treat medical conditions; and include programmatic guidelines for sharps disposal, staff training, data collection and program evaluation and community relations.

The syringe services program shall offer services as every visit from a qualified health care provider, shall exclude minor from participation in the syringe exchange, but may provide minors with harm reduction services, shall ensure a syringe is unique to the program, shall distribute with a goal of a 1:1 model, may substitute weighing the volume of syringes returned versus dispensed as specified: This substitution is only permissible if it can be done accurately and if the syringes are in a see-through container and a visual inspection of the container takes place prior to the syringes being weighed, the syringes are distributed directly to a recipient, and proof of WV identification is required upon dispensing the needles.

The bill requires staff shall be trained on the requirements of the program, the services provided by the program, the applicant's policies and procedures concerning syringe exchange, disposing of infectious waste, procedures for obtaining or making referrals, opioid antagonist administration, cultural diversity and sensitivity to protected classes under state and federal law, completion of attendance logs for participation in mandatory training, maintain a program for the public to report syringe litter and shall endeavor to collect all syringe litter in the community.

The bill requires the syringe services program to have a syringe dispensing plan which includes: maintaining records of returned syringes by participants for two years, preventing syringe stick injuries, tracking the number of syringes dispensed, tracking the number of syringes collected, tracking the number of syringes collected as a result of community reports of syringe litter, eliminating direct handling of sharps waste, following a syringe stick protocol and plan, a budget for sharps waste disposal or an explanation if no cost is associated with sharps waste disposal, a plan to coordinate with the continuum of care.

The bill includes a procedure for revocation or limitation of the syringe services program and administrative due process. The bill provides for administrative appeals and judicial review. The bill has reporting requirements, a section for renewal, and provides for emergency rulemaking to occur by July 1, 2021.

There is a section for immunity. The bill provides that notwithstanding any provision of the code to the contrary, an employee, volunteer, or participant of a licensed syringe services program may not be arrested, charged with, or prosecuted for possession of any of the following:

- Sterile or used syringes, hypodermic syringes, injection supplies obtained from or returned to a program, or other safer drug use material obtain from a program established pursuant to this article, including testing supplies for illicit substances.
- Residual amounts of a controlled substance contained in a used syringe, used injection supplies obtained from or returned to a program.
- A law enforcement officer who, acting on good faith, arrests or charges a person who is thereafter determined to be entitled to immunity from prosecution under this section is not liable for the arrest or filing of charges.
- An individual who is wrongly detained, arrested, or prosecuted under this section shall have the public record associated with the detainment, arrest or prosecution expunged.
- A health care professional, or an employee or volunteer of a licensed syringe services program is not subject to sanction, detainment, arrest, or prosecution for carrying out the provisions of this article.
- A business that has syringe litter is immune from civil or criminal liability in any action relating to the needle on its property unless the business owner acted in reckless disregard for the safety of others.

The bill provides the Office of Health Facilities Licensure and Certification may assess an administrative penalty of not less than \$500 nor more than \$10,000 per violation of this article. The office may also seek injunctive relief.

The bill provides that a syringe services program shall coordinate care with other health care providers;

In the event that the syringe service program is closed, the program shall notify the participant of the closure of the service, prior to closure, in a conspicuous location, and provide an individual with a transition care plan;

The Bureau for Medical services shall submit a state plan amendment to permit harm reduction programs to be an eligible provider, except that the syringe exchange services shall not be eligible for reimbursement under the state plan.

The bill provides that upon passage, an existing provider not offering the full array of harm reduction services as set forth in this section shall cease and desist offering all needle exchange services. The bill

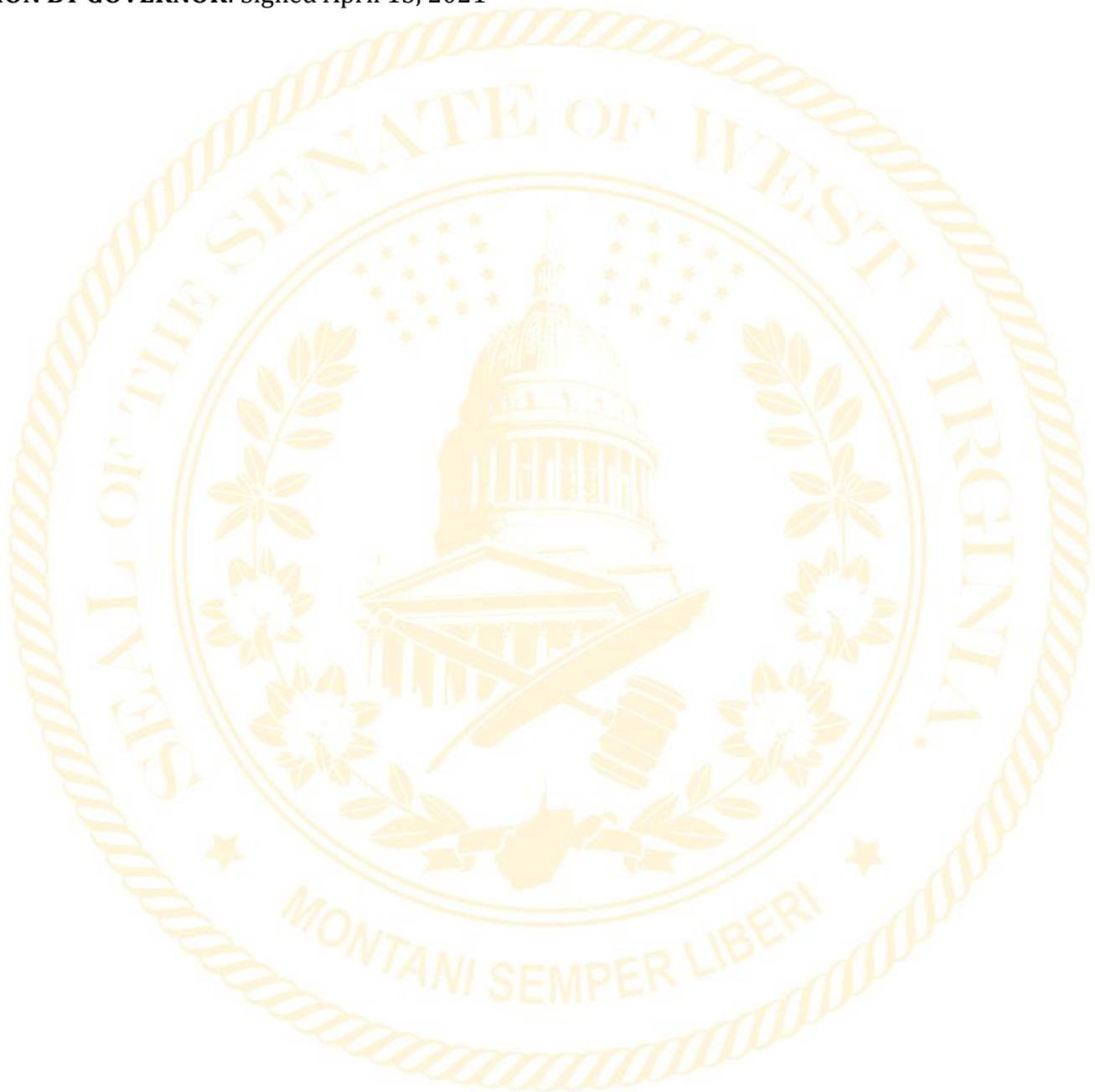
provides that any provider offering the full array of harm reduction services shall have until January 1, 2022 to come into compliance. Any new provider shall have until January 1, 2022 to come into compliance.

CODE REFERENCE: West Virginia Code §16-63-1 through §16-63-10 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Signed April 15, 2021



Senate Bill 372

Providing greater discretion to WV Board of Medicine to approve graduate clinical training

The bill permits the West Virginia Board to Medicine discretion to consider additional criteria when determining whether an applicant has successfully completed graduate clinical training. Currently, in order to satisfy these criteria an applicant must complete a program which is approved by the Accreditation Council for Graduate Medical Education.

This bill provides that the board can determine the applicant has met the criteria for graduate clinical training when an institution that sponsors or operates a residency program in the same clinical field or a related field is approved by the Accreditation Council for Graduate Medical Education or at a time when accreditation was not available for the fellowship's clinical field and the board determined the training was similar to accredited training due to objective standards then the board could issue a license if all other criteria are met. The statute also permits the applicant also to use fellowship training in combination with board certification to meet the qualification for licensure.

The bill clarifies that a temporary license issued by the board authorized the holder to practice medicine and surgery in WV for the term of the temporary license and includes full prescriptive authority. The bill permits the board to include in legislative rules the fee for the temporary license and the criteria for the temporary permit application.

CODE REFERENCE: West Virginia Code §30-3-10 and §30-3-11 – amended

DATE OF PASSAGE: March 9, 2021

EFFECTIVE DATE: March 9, 2021

ACTION BY GOVERNOR: Signed March 19, 2021

Senate Bill 397

Relating to health care provider tax

This bill would modify the health care provider tax. It clarifies that critical access hospitals are not “acute care hospitals for purposes of the health care provider tax. Additionally, the bill modifies significant dates set out in the bill by changing the effective date to July 1, 2021 and eliminating the expiration date of June 30, 2021.

CODE REFERENCE: West Virginia Code §11-27-39 – amended

DATE OF PASSAGE: April 7, 2021

EFFECTIVE DATE: Passage

ACTION BY GOVERNOR: Signed April 21, 2021

Senate Bill 398

Limiting eligibility of certain employers to participate in PEIA plans

This bill amends the provisions of the West Virginia Code by adding a new section. The new section would eliminate eligibility of certain employers to participate in PEIA. On or after July 1, 2021, employers eligible for participation in PEIA are limited to:

- mandatory participants – the State, its boards, agencies, commissions, departments, institutions or spending units;
- county boards of education or public charter schools that are also 501(c)(3) corporations and have participation required in their charter contract;
- any employer currently participating in PEIA as of the effective date of the bill.

Any county or municipality, public corporations created by counties or municipalities, comprehensive community health centers, county or municipal health departments that are not already participating in PEIA would be ineligible to participate after effective date of the bill.

CODE REFERENCE: West Virginia Code §5-16-29 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: April 10, 2021

ACTION OF GOVERNOR: Signed April 21, 2021

Senate Bill 390

Reorganizing Health Care Authority under DHHR and clarifying responsibilities for all-payer claims database

The bill sets forth the parties to the Memorandum of Understanding for purposes of establishing the All-Payer Claims Database.

The bill provides the Secretary of DHHR has primary responsibility for retention and dissemination of data in the APCD. The Insurance Commissioner has primary enforcement responsibility. The Secretary shall provide for the development of a plan for the financial stability of the APCD and shall provide for the use of the uniform discharge data collected by the West Virginia DHHR.

Health care payers shall submit data to the Secretary or a designated entity. Data is considered confidential. The data shall be available as a resource for the secretary and commissioner to conduct public health analyses, conduct program evaluations, review health care utilization, expenditures, and performance in West Virginia, to conduct research, and to enhance the ability of consumers to make informed and cost-effective health care decisions.

The bill provides data submitted is available as a resource for insurers, researchers, employers, providers, purchasers of healthcare, consumers, and state agencies. The bill provides the use shall be limited to public health, research, consumer reporting and program evaluation purposes.

The bill provides a reasonable user fees may be set by the secretary and established in legislative rules. The bill provides the Secretary may waive fees if he or she determines the user is unable to pay.

In the event there is a violation, the Secretary may seek to enjoin any further action. A special revenue account is created. The bill gives the Secretary and the Commissioner rulemaking authority.

CODE REFERENCE: West Virginia Code §33-4A-1 through §33-4A-8 – amended

DATE OF PASSAGE: March 26, 2021

EFFECTIVE DATE: March 26, 2021

ACTION BY GOVERNOR: Signed April 7, 2021

Senate Bill 437

Extending contingent increase of tax rate on certain eligible acute care hospitals

This bill would modify the health care provider tax. It clarifies that critical access hospitals are not “acute care hospitals for purposes of the health care provider tax. Additionally, the bill modifies significant dates set out in the bill by changing the effective date to July 1, 2021 and eliminating the expiration date of June 30, 2021.

CODE REFERENCE: West Virginia Code §11-27-38 – amended

DATE OF PASSAGE: April 5, 2021

EFFECTIVE DATE: Passage

ACTION BY GOVERNOR: Signed April 15, 2021

Senate Bill 644

Exempting certain persons pursuing degree in speech pathology and audiology from license requirements

The bill exempts persons seeking a degree in audiology from obtaining a license as a hearing aid dealer. The person seeking the degree must meet specified requirements. The person must be part of a planned course of study, they are designated by a title such as intern, trainee, student, and they work under the supervision of a person licensed by the state to practice audiology.

CODE REFERENCE: West Virginia Code §30-36-2 – amended

DATE OF PASSAGE: April 6, 2021

EFFECTIVE DATE: July 5, 2021

ACTION BY GOVERNOR: Signed April 15, 2021

Senate Bill 668

Creating Psychology Interjurisdictional Compact

This bill makes West Virginia a participant in the interstate compact created by the Association of State and Provincial Psychology Boards (ASPPB) to form an interstate compact. An “Interstate Compact” establishes a formal, legal relationship among states to promote a common agenda.

The common agenda of this compact is to increase access to psychological care by facilitating: tele-psychological services and the temporary face-to-face practice of psychology across jurisdictional boundaries.

This interstate compact is referred to nationally as The Psychological Interjurisdictional Compact (PSYPACT). Like most others, it establishes uniform guidelines, standards, and/or procedures for agencies in the compact’s member states. At present, 15 states and the District of Columbia have enacted laws adopting PSYPACT and 17 states have pending legislation to do so.

The adoption of this compact makes no change to the criteria or qualifications used to determine whether or not a particular individual becomes a licensed psychologist in this state.

Even if licensed in a particular state, an individual psychologist must apply and be approved by the ASPPB in order to conduct tele-psychological services or temporary face-to-face practice of psychology in other states. Conversely, if adverse action is taken against a psychologist who is participating in the compact, he or she may be made ineligible for further participation.

The bill also permits any Compact State to withdraw from the Compact by enacting a statute that repeals its adoption.

CODE REFERENCE: West Virginia Code §5-16-29 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: April 10, 2021

ACTION OF GOVERNOR: Signed April 21, 2021

Senate Bill 671

Appointing Director of Office of Emergency Medical Services

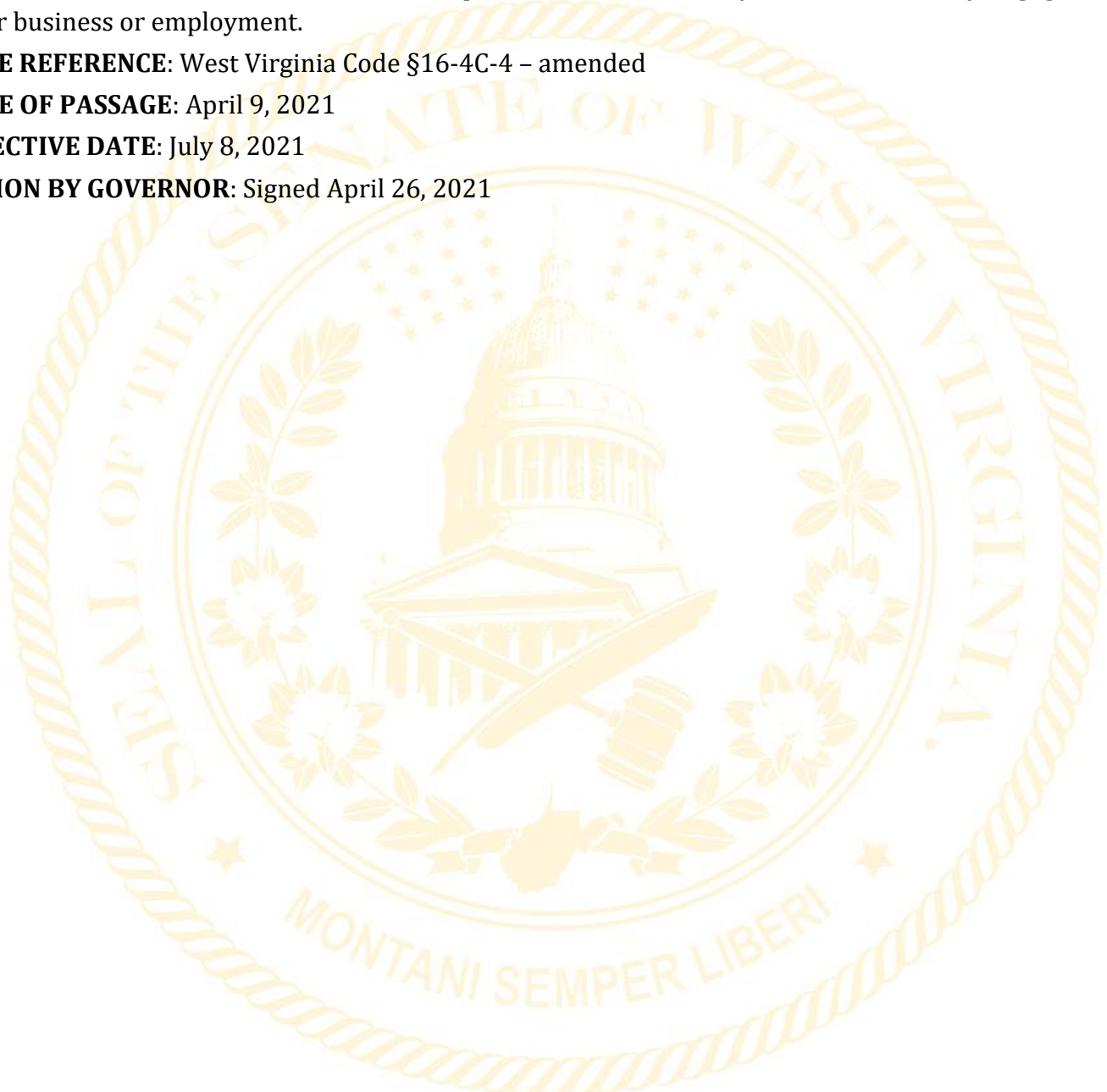
The bill requires the Office of Emergency Medical Services Director to be appointed by the Department of Health and Human Resources Secretary. The bill sets forth the requirements of the office to include being experienced in the delivery and administration of emergency medical services and related prehospital care. The director shall serve at the will and pleasure of the Secretary and not be actively engaged in any other business or employment.

CODE REFERENCE: West Virginia Code §16-4C-4 – amended

DATE OF PASSAGE: April 9, 2021

EFFECTIVE DATE: July 8, 2021

ACTION BY GOVERNOR: Signed April 26, 2021



Senate Bill 702

Relating to involuntary hospitalization, competency, and criminal responsibility of persons charged or convicted of certain crimes

This bill modifies the law pertaining to a criminal defendant's competency to stand trial and criminal responsibility as follows:

- Defines several new terms used in Article 6A; and modifies the requirements, procedures, and timeframe for initial forensic evaluations as to a criminal defendant's competency to stand trial;
- Addresses certain non-state-operated mental health facilities' obligations to admit and treat criminal defendants and ability to purchase liability coverage from the Board of Risk and Insurance Management;
- Authorizes rulemaking by the Department of Health and Human Resources to implement the provisions of Article 6A;
- Modifies the requirements, procedures, and timeframe for a court's determination of competency to stand trial, and subsequent competency restoration, release, and review of a defendant's circumstances; and imposes requirements, procedures, and timeframe for review and subsequent disposition of certain individuals currently under commitment;
- Modifies the requirements, procedures, and timeframe for forensic evaluations of criminal responsibility or diminished capacity and for dangerousness evaluations of defendants found not guilty by reason of mental illness;
- Modifies the requirements, procedures, and timeframe for disposition of defendants found not guilty by reason of mental illness and subsequent oversight of acquittees who are either involuntarily hospitalized or conditionally released;
- Extends sentence credit to time spent in a state hospital;
- Requires the Department of Health and Human Resources to pay for all competency restoration services not covered by other government, third-party funding sources, or other grant agreements;
- Extends the right to receive treatment to individuals who are court ordered to a state hospital;
- Provides that treatment includes medication management intended to treat an individual's condition that causes or contributes to incompetency; and
- Establishes a Dangerousness Assessment Review Board to provide opinion, guidance, and informed objective expertise, at the request of a circuit judge, as to the appropriate level of custody or supervision necessary to ensure persons who are judicially determined to be incompetent to stand trial and not restorable or not guilty by reason of mental illness are in the least restrictive environment available to protect the person, other persons, and the public generally.

CODE REFERENCE: West Virginia Code §27-6A-12 – repealed; §27-6A-1, §27-6A-2, §27-6A-3, §27-6A-4, §27-6A-5, §27-6A-6, §27-6A-8, and §27-6A-10 – amended; §27-6A-13 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Signed April 28, 2021

Senate Bill 714

Relating to physician assistant practice act

The bill eliminates the practice agreement between a physician assistant and the physician. The practice agreement was a document that was approved by the licensing board. In lieu of the practice agreement there is a practice notification which may be kept on file at the practice.

Definitions were removed for advance duties, alternative collaborating physician, and practice agreement. With respect to the definitions for approved program an alternative program was added. The practice notification was modified to reflect that it could be written or electronic and kept on file and made upon to the boards upon request.

The rulemaking provision is modified to reflect prescriptive authority for schedule II drugs for no more than a three-day supply with no refills for both physician assistants and advance practice registered nurses. Additionally, other provisions from this section are removed that relate to prescribing, dispensing, and administering of controlled substances, rules referencing attestations, and a rule regarding the notice of intent to delegate prescribing of controlled substances.

The bill states that the appropriate licensing board shall issue a license to practice as a physician assistant with the collaboration of the board's licensed physician to a person who, among other enumerated items, has certification from the National Commission on Certification of Physician Assistants or has a current license in good standing from a state that does not require a physician assistant to maintain a national certification.

With respect to practice requirements, new requirements are included that state a physician assistant may practice in collaboration with physicians in any practice setting pursuant to a practice notification which has been filed with and active by the appropriate board, provided that a physician assistant who is currently practicing in collaboration with physicians pursuant to a practice agreement which was authorized by a board prior to June 1, 2021 may continue to practice under that authorization until the practice agreement terminates or until June 1, 2022 whichever is sooner. The bill provides that notwithstanding any other provisions to the contrary, physician assistants shall be considered providers and shall not be reimbursed at rates lower than other providers who render similar health services by health insurers as well as health plans operated or paid for by the state.

With respect to practice notification requirements, before the physician assistant my practice in collaboration with physicians, the physician and a health care facility shall, file a practice notification with the licensing board, pay the applicable fee, receive written notice from the appropriate board that the practice notification is complete and active.

With respect to collaboration with physician assistants, a health care facility, a physician who practices medicine or podiatry at a health care facility may collaborate with any physician assistant who holds an active practice notification with the same facility. When collaborating with physician assistants, collaborating physicians, shall observe, direct, and evaluate the physician assistant's work, records, and practices as necessary for appropriate and meaningful collaboration.

With respect to scope of practice, a license issued by the appropriate licensing board authorized the physician assistant to perform medical acts: commensurate with their education, training, and experience and which they are competent to perform, consistent with the rules of the boards. Medical acts include prescribing, dispensing, and administering controlled substances, prescription drugs, or medical devices. A physician assistant shall only provide those medical services that they have been prepared by their

education, training and experience and are competent to perform. This may occur in any setting, both hospital and outpatient in accordance with the practice notification.

The complaint process is revised to remove references to collaborating physician or alternative.

CODE REFERENCE: West Virginia Code §30-3E-10 – repealed; §30-3E-1, §30-3E-2, §30-3E-3, §30-3E-4, §30-3E-9, §30-3E-10a, §30-3E-11, §30-3E-12, §30-3E-13, and §30-3E-17 – amended

DATE OF PASSAGE: April 9, 2021

EFFECTIVE DATE: July 8, 2021

ACTION BY GOVERNOR: Signed April 21, 2021



House Bill 2005

Relating to health care costs

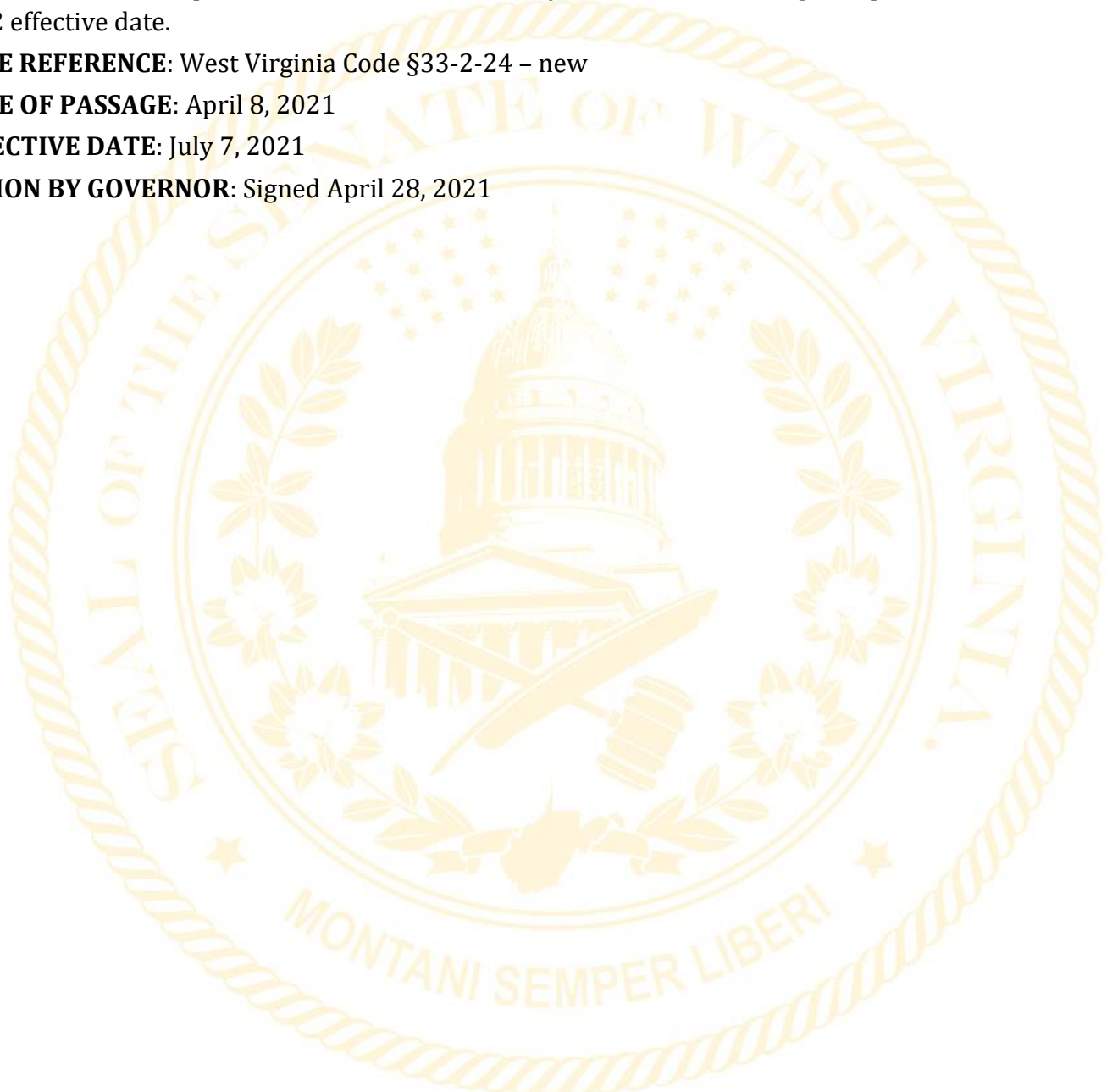
The bill requires the Insurance Commissioner to enforce the No Surprises Act H.R.133, Public Law 116-260 and gives powers to enforce including the ability to assess a fine of up to \$10,000 per violation; administrative penalties; the ability to seek guidance from other regulatory agencies; the ability to seek legal assistance or representation from the Attorney General; rulemaking and provides for a January 1, 2022 effective date.

CODE REFERENCE: West Virginia Code §33-2-24 – new

DATE OF PASSAGE: April 8, 2021

EFFECTIVE DATE: July 7, 2021

ACTION BY GOVERNOR: Signed April 28, 2021



House Bill 2024

Expand use of telemedicine to all medical personnel

The bill regulates telehealth services. The bill applies to all health care practitioners licensed pursuant to chapter 30, including physicians (MD & DO), physician assistants, dentists, pharmacists, nurses, practical nurses, veterinarians, chiropractors, physical therapists, athletic trainers, psychologists, radiologist technicians, hearing aid dealers, occupational therapists, social workers, licensed. Unless provided for by statute or legislative rule, a health care board shall propose an emergency rule to regulate telehealth by rule. The rule shall include the following:

- The practice of the health care service occurs where the patient is located at the time the telehealth services are provided;
- The health care practitioner who practices telehealth shall be:
 - Licensed in good standing in all states in which he or she is licensed and not currently under investigation or subject to administrative complaint;
 - Registered as an interstate telehealth practitioner with the appropriate board in West Virginia.
- When the health care practitioner-patient relationship is established.
- With respect to the standard of care with respect to the established patient, the patient shall visit an in-person health care practitioner within 12 months of using the initial telemedicine service or the telemedicine service shall no longer be available to the patient until the in-person visit is obtained. This requirement may be suspended, in the discretion of the health care practitioner on a case-by-case basis and it does not apply to acute inpatient care, post-operative follow up checks, behavioral medicine, addiction medicine, or palliative care.
- A prohibition on controlled substance listed in Schedule II drugs, provided that these prescribing limitations do not apply to a physician or a member of the same group practice with an established patient.
- Establish the conduct of a registrant for which discipline may be imposed by the board of registration.
- Establish a fee, not to exceed the amount to be paid by a licensee, to be paid by the telehealth practitioner in this state.
- A reference to the Board's discipline process.
- A registration issued pursuant to the provisions of, or the requirements of this section authorize a health care professional to practice from a physical location within this state without first obtaining appropriate licensure.
- By registering to provide interstate telehealth services to patients in this state, a health care practitioner is subject to: the laws regarding the profession in this state, the jurisdiction of the board, notifying them of any restrictions on his or her license, and a person currently licensed in this state is not subject to registration.

The bill amends the telemedicine practice act for the Board of Medicine and the Osteopathic Board. The bill removes language, in both acts, that prevented a physician-patient relationship from being started via audio-only communication and specifically provides that the physician-patient relationship can be established through the use of audio-only calls or conversations that occur in real time.

With respect to prescribing limitations, both acts have limitations on the prescription of schedule II drugs but have an exception for established patients.

Both boards have emergency rulemaking to pass a rule consistent with the legislative changes made during the 2021 Legislative session.

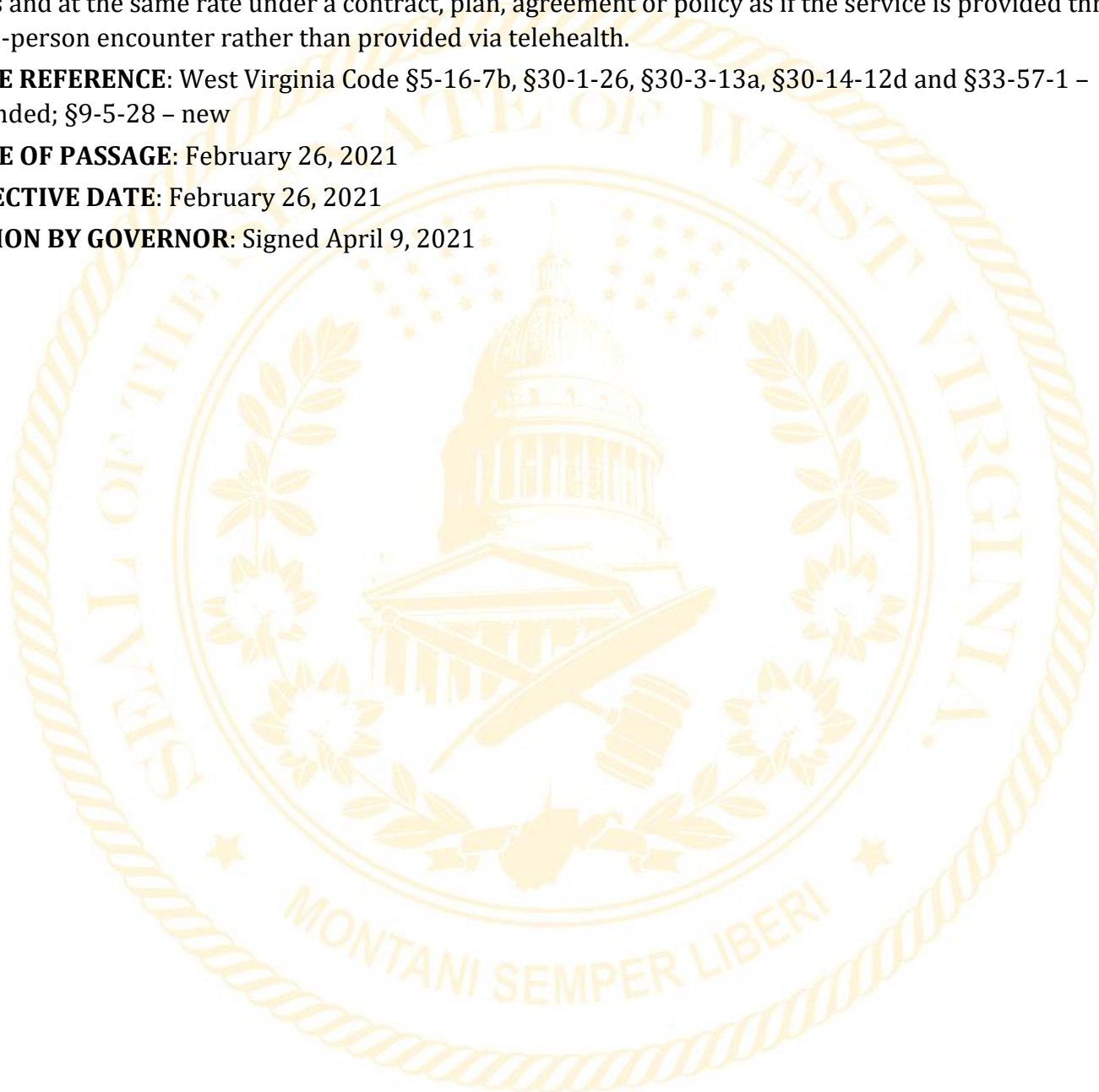
The bill requires PEIA and other health insurers which issues, renews, amends, or adjusts a plan, policy, contract or agreement on or after July 1, 2021 to pay a negotiated rate for a virtual telehealth encounter and shall provide reimbursement for a telehealth service for an established patient or care rendered on a consulting basis to a patient, located in an acute care facility whether inpatient or outpatient on the same basis and at the same rate under a contract, plan, agreement or policy as if the service is provided through an in-person encounter rather than provided via telehealth.

CODE REFERENCE: West Virginia Code §5-16-7b, §30-1-26, §30-3-13a, §30-14-12d and §33-57-1 – amended; §9-5-28 – new

DATE OF PASSAGE: February 26, 2021

EFFECTIVE DATE: February 26, 2021

ACTION BY GOVERNOR: Signed April 9, 2021



House Bill 2028

Exempting veterinarians from the requirements of controlled substance monitoring

The bill states that a veterinarian is exempt from the requirements of the article establishing the West Virginia Controlled substances monitoring database.

CODE REFERENCE: West Virginia Code §60A-9-2 – amended

DATE OF PASSAGE: April 5, 2021

EFFECTIVE DATE: July 4, 2021

ACTION BY GOVERNOR: Signed April 19, 2021

House Bill 2093

Relating to exemptions for the United States Department of Veterans Affairs Medical Foster Homes

The bill provides an exemption for any home or facility approved and annually reviewed by the United States Department of Veterans Affairs as a medical foster home in which care is provided to three or fewer veterans from the registration and inspections of legally unlicensed health care homes. These homes are inspected by the Department of Health and Human Resources and this bill would provide an exemption to this article.

The proposed bill would require the West Virginia Department of Veterans Affairs to report annually by December 1, to the Governor outlining the scope and effectiveness of the medical foster care program for veterans.

The bill also provides that medical foster homes approved and annually reviewed by the United States Department of Veterans Affairs is excluded from the facilities required to use WV Cares to background check its employees.

CODE REFERENCE: West Virginia Code §16-49-1 – amended; §16-5E-3a – new

DATE OF PASSAGE: April 7, 2021

EFFECTIVE DATE: July 6, 2021

ACTION BY GOVERNOR: Signed April 19, 2021

House Bill 2221

Relating to the establishment of an insurance innovation process

This bill creates a new article in the insurance code, relating to “Insurance Innovation.”

In effect, the bill creates a “sandbox” meant to be a regulatory safe space for entrepreneurs to test and launch insurance-related products not yet contemplated by the state insurance code. Companies wishing to participate in the sandbox would apply to the Offices of the Insurance Commissioner (“OIC”) for admission. The applicant would have to explain the product’s innovation, explain the value to customers, and demonstrate financial stability. Participants would be required to report key data to the OIC for ongoing evaluation and oversight. A sandbox law for financial products passed in West Virginia during the 2020 Regular Session (House Bill 4621 West Virginia FinTech Regulatory Sandbox Act).

Specifically, the bill does the following:

In §33-60-1, the bill defines terms, including “applicant”, “beta test”, “client”, “commissioner”, “extended no-action letter”, “innovation’s utility”, “innovation”, “limited no-action letter” or “limited letter”, “participant”, “qualified United States financial institution”, and “regulatory sandbox”.

In §33-60-2, the bill details the requirements for application to the OIC for admission into the regulatory “sandbox”. The deadline for application is December 31, 2025, and the fee is \$750. The application, on a form prescribed by the OIC, must include the following:

- An explanation on the value of the innovation to the public; its economic viability; and its safety;
- A detailed description of the statutory and regulatory issues that prevents the innovation from being made available currently;
- A certification that no like innovation is available in West Virginia;
- Contact information for the applicant’s insurance regulatory counsel;
- A detailed description of the specific conduct that the applicant proposes should be permitted by the limited no-action letter (a letter detailing what conduct will not result in regulatory action by the OIC during the testing phase or “beta test”);
- Proposed terms and conditions to govern the applicant’s beta test;
- Proposed metrics by which the commissioner may reasonably test the innovation’s utility during the beta test;
- Disclosure of certain interested parties;
- A statement that the applicant has funds of at least \$25,000 available to guarantee its financial stability; and
- A statement confirming that the applicant authorized to make an application.
- Certain persons would be prohibited from making application for admission to the regulatory sandbox. (See §33-60-2(b)).

In §33-60-3, the bill contains the criteria for OIC’s acceptance or rejection of an application, which must be made within 60 days, but may be extended for an additional 30 days with notice to the applicant. If the OIC does not act on the application, it is deemed accepted. The OIC may request information from the applicant as necessary to evaluate the application and must review the application based on various criteria. If the application is rejected, the OIC would have to explain the defects. If accepted, the OIC would have to issue a notice of acceptance that sets forth requirements and conditions. The notice would expire unless accepted in writing within 60 days. The applicant would be entitled to request a hearing on the decision of the OIC.

In §33-60-4, the bill provides that the OIC is required to issue a “limited no action letter” within 10 days of acceptance. Such letter would describe the OIC enforcement exemptions that the participant will secure so long as the participant operates within the terms and conditions set forth in the letter. The OIC would be required to publish all such letters on its website.

In §33-60-5, the bill provides that the beta test period would be for three years unless extended for another year. This section also sets forth the penalties for non-compliance with the limited no action letter or failure to provide the OIC with requested information, which includes termination of the beta test and safe harbor of the limited no action letter and fines of up to \$2,000 per violation. If the beta test is causing consumer harm, the OIC may order a stop. A participant or client could request a OIC hearing on any penalty.

In §33-60-6, the bill provides that the OIC must issue an extended no-action letter within 60 days of the conclusion of the beta test (unless extended up to 30 days) or a letter declining to extend such a letter. The OIC would be required to review the results of the beta test considering factors such as utility, publishing the result on its website. If certain criteria are met, the OIC could issue and publish an extended no-action letter (permitting continued use of the innovation) for up to three years. An extended no-action letter could be modified only by the Legislature or, upon complaints and a showing of risk of harm to consumers, rescinded by the OIC.

In §33-60-7, the bill requires the OIC to keep documents, materials, or other information in the possession or control of the commissioner that are created, produced, obtained, or disclosed in relation to this article and that relate to the financial condition of any person or entity confidential and privileged. Such information would not be subject to FOIA, subpoena, or discovery, and not admissible in evidence in any private civil action.

In §33-60-8, the bill requires that the OIC report to the legislature on the program. The bill also specifies content requirements of such reports.

In §33-60-9, the bill allows the OIC to enter into reciprocity agreements with state, federal, or foreign regulatory agencies, making the WV insurance innovation available in other jurisdictions, and vice versa as to innovations from other jurisdictions under standards of this new article.

In §33-60-10, the bill requires rulemaking by the Insurance Commissioner for purposes of administering this article and requires the development of forms, contracts, and other documents as necessary.

CODE REFERENCE: West Virginia Code §33-53-1 through §33-53-10 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Signed April 15, 2021

House Bill 2260

Relating to procurement of child placing services

The bill changes the performance-based contract from a procurement to a service contract. This means the Department of Health and Human Resources is no longer required to go through the purchasing department with this process. The deadline for contract placement was extended from December 1, 2020 to July 1, 2021. The bill provides the department shall actively consult with other state agencies with expertise in performance-based contracting to develop the performance-based contract and that contracts for child placing agencies are exempt from purchasing.

CODE REFERENCE: West Virginia Code §49-1-111a – amended

DATE OF PASSAGE: March 31, 2021

EFFECTIVE DATE: March 31, 2021

ACTION BY GOVERNOR: Signed April 9, 2021

House Bill 2262

Relating to the controlled substance monitoring database

This bill adds a requirement that a pharmacist check the controlled substances monitoring database. The bill also removes a requirement that a veterinarian maintain an access to the controlled substance access database and check it upon dispensing any Schedule II controlled substance, any opioid, or any benzodiazepine and at least annually thereafter.

CODE REFERENCE: West Virginia Code §60A-9-5 and §60A-9-5a – amended

DATE OF PASSAGE: March 2, 2021

EFFECTIVE DATE: May 31, 2021

ACTION BY GOVERNOR: Signed March 10, 2021

House Bill 2263

Update the regulation of pharmacy benefit managers

The bill updates the regulation of pharmacy benefits managers. The first section of the bill clarifies information PEIA is required to provide concerning its contract with its PBM. This includes: The overall total amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter and the overall total amount of reimbursements paid to pharmacy providers during the quarter. Finally, PEIA must report the overall total number of claims in which the pharmacy benefits manager reimbursed a pharmacy provider for less than the amount charged to the agency for all claims processed by the pharmacy benefit manager during the quarter;

Based upon a recent United State Supreme Court case, ERISA plans are subject to state regulation and this exemption is removed from the current statute.

The bill requires a PBM to reimburse a pharmacy at least the national avg drug acquisition cost and the dispensing fee of at least \$10.49. If the NADAC cost is not available, then the PBM may not reimburse in an amount less than the wholesale acquisition cost of the drug plus a professional dispensing fee of \$10.49;

A PBM can't reimburse an affiliate more than it reimburses another pharmacy;

It requires PBMs to file its reimbursement methodologies with Office of Insurance Commissioner and these methodologies are treated as confidential;

It prohibits a PBM from discriminating in reimbursement, assess any fee or adjustment or exclude a pharmacy subject to 42 U.S.C. 256b or in any way bases is pharmacy reimbursement for a drug on patient outcomes, scores, or metrics;

It requires the PBM to offer all rebates at the point of sale. Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums. Nothing prevents an insurer from decreasing a covered individual's cost sharing by an amount greater than what is previously stated. Provides for the Insurance Commissioner may propose rules to effectuate this subsection.

It provides an effective date of January 1, 2022 for the amendments made to this article;

It requires the PBM to accept any pharmacy that is willing to accept its contract; and, it requires reporting to the Insurance Commissioner.

CODE REFERENCE: West Virginia Code §5-16-9, §33-51-2, §33-51-3, §33-51-8, and §33-51-9 – amended; §33-51-11 and §33-51-12 – new

DATE OF PASSAGE: March 30, 2021

EFFECTIVE DATE: June 28, 2021

ACTION BY GOVERNOR: Signed April 9, 2021

House Bill 2266

Relating to expanding certain insurance coverages for pregnant women

The bill extends Medicaid coverage for pregnant women and their newborn infants to 1-year postpartum, from the current 60 days postpartum. This would be effective July 1, 2021 or as soon as federal approval occurs. The current law provides coverage to 185% of the federal poverty level and this was an increase from 150% which was changed in 2019.

The bill provides that any woman who established eligibility shall continue to be treated as an eligible individual without regard to any change in income of the family of which she is a member until the end of the one-year period beginning on the last day of her pregnancy.

Pregnant women have been covered under by Medicaid under the Public Health Emergency (PHE), Maintenance of Effort (MOE) requirement for FY2021. The MOE provides continuous coverage for Medicaid enrollees through the end of the PHE. The Biden Administration has indicated that the PHE could realistically extend through December 31, 2021. The American Rescue Plan, passed on March 11, 2021, provides states in both Medicaid and CHIP the option to provide full benefits to pregnant and postpartum women during pregnancy and for one year postpartum. States choosing to use this option in Medicaid must also make the option available for pregnant and postpartum women covered under CHIP. The option becomes available on the first day of the first fiscal quarter one year after enactment of the statute. It is available for five years after that date.

CODE REFERENCE: West Virginia Code §9-5-12 – amended

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: Passage

ACTION BY GOVERNOR: Signed April 28, 2021

House Bill 2368

Myliisa Smith's Law, creating patient visitation privileges

The bill amends the Patient Safety and Visitation Act of 2001.

The bill amends §16-39-1 relating to the short title to indicate that the amendments made to this article during the 2021 Regular Session of the Legislature shall be known as "Myliisa Smith's Law".

The bill repeals §16-39-2 relating to legislative findings and purpose.

The bill amends §16-39-3 by adding new definitions for healthcare facility, patient, public health state of emergency, and visitor.

The bill adds a new section §16-39-8 relating to visitation of a patient in a health care facility. This new section provides:

- During a declared public health state of emergency for a contagious disease, a health care facility shall permit visitation of a patient in a manner consistent with applicable federal and state laws, regulations, rules, policies, and guidance. If the patient's death is imminent, the health care facility shall allow visitation upon request at any time and frequency. In all other instances, the health care facility shall allow visitation not less than once every five days.
- A visitor shall comply with the applicable procedures established by the health care facility.
- The health care facility may deny a visitor entry to the health care facility, may subject a visitor to expulsion from the facility, or may permanently revoke visitation rights to a visitor who does not comply with the applicable procedures established by the health care facility.
- A healthcare facility is not liable to a person visiting another person, nor to any other patient or resident of the health care facility, for any civil damages for injury or death resulting from or related to actual or alleged exposure during, or through the performance of, the visitation in compliance with this section, unless the health care facility failed to substantially comply with the applicable health and safety procedures established by the health care facility.

CODE REFERENCE: West Virginia Code §16-39-1, §16-39-2, and §16-39-3 – amended; §16-39-8 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: April 10, 2021

ACTION BY GOVERNOR: Signed April 28, 2021

House Bill 2427

Authorizing the Department of Health and Human Resources to promulgate legislative rules.

This is rules Bundle 5 relating to the Department of Health and Human Resources (DHHR). It contains 14 rules, 13 of which are from DHHR and one from the Health Care Authority. Only the legislative rules directly relating to the health care industry are included in this summary.

West Virginia Health Care Authority, Behavioral Health Centers Licensure, 64 CSR 11

The rule amends a current legislative rule. The purpose of the rule is to establish standards for the licensure of behavioral health services and supports. Some of the more substantive changes to the sections are listed below.

§ 64-11-2. Application and Enforcement.

A new subsection 2.7 provides that if a facility otherwise exempt wants to be licensed, that facility must follow the application procedures in this rule.

§ 64-11-3. Definitions.

A definition for the term behavioral health center has been added.

§ 64-11-4. State Administrative Procedures.

A new subdivision 4.5.3 requires new construction to use the most current guidelines for design and construction.

§ 64-11-5. Consumer Rights.

A new subsection 5.4 requires providers to develop and implement a code of conduct that includes, but is not limited to, provisions regarding informed consent and participation of consumer in decisions about services.

§ 64-11-7. Legal Compliance.

A new subsection 7.4 is requires a behavioral health center to have a governing body, which is to develop, maintain, and implement a conflict-of-interest policy and procedures for managing conflicts and to evaluate implementation of policies and procedures.

A new subdivision 7.5.9. governs the release of consumer information and records. This section provides that the behavioral health center may release consumer information only in accordance with its written policies and in compliance with applicable federal and state laws. This section sets forth criteria for record maintenance.

§ 64-11-8. Financial Management.

An amendment to subdivision allows individual consumer funds to be maintained in one account for all consumer funds. However, an individual accounting for each consumer must be maintained and one consumer's funds may not be used for the expenses of another consumer.

§ 64-11-9. Management of Human Resources.

A new subdivision 9.2.4 requires staff providing direct care to consumers to be 18 years of age or older and capable of performing the duties assigned.

A new subdivision 9.2.12 requires the provider to have an adequate number of qualified personnel to meet the consumers' assessed needs and treatment plan or treatment strategy.

§ 64-11-10. Service Environment.

Amendments to this section relate to bathrooms, documentation of water temperature, treatment of solid waste, plumbing, vermin, refrigerator and freezer temperature logs, removal of structural barriers, fire drills, housekeeping, storage, infection control, and emergency preparedness.

§ 64-11-11. Compliance with Legal, Health and Regulatory Requirements.

Amendments to this section relate to changes in a consumer's condition, medication information for the consumer, double locking of controlled substances, and policies and procedures for handling medical and psychiatric emergencies.

§ 64-11-12. Services.

This section contains provisions relating to the intake process to assess a consumer, requirements for the assessment, written consent prior to initiating treatment, treatment plan requirements, diagnoses, consumer records, review of treatment plans or treatment strategies, discharge planning, medication services, critical incidents, restraints, and transfer to an appropriate acute care facility for a consumer who poses an imminent physical danger to himself, herself, or others.

§ 64-11-13. Administrative Due Process, Administrative Appeals, and Judicial Review.

This section contains provisions relating to civil monetary penalties for operating an unlicensed facility and the limitation suspension or revocation of a license.

The rule requires that in all new construction and alterations, all plumbing must meet national plumbing codes or in the absence thereof, the National Plumbing Code; removes the requirement that a facility check the water temperature of all mixing faucets daily; requires immediate in-home access for staff to relevant information in a consumer's medical record; and provides that the Secretary may only suspend or revoke a license if the licensee commits a violation that endangers the health, safety or welfare of a person.

West Virginia Department of Health and Human Resources, Hospital Licensure, 64 CSR 12

The rule amends a current legislative rule. The rule establishes standards and procedures for the licensing of hospitals and extended care facilities operated in connection with a hospital. Senate Bill 767 passed during the 2020 Regular Session of the Legislature repealed §16-5B-6a which required all nonprofit and all hospitals owned by any county, city, or other political subdivision to have boards with a 40% consumer representative make-up. References to a Section 6a hospital and the requirements for these hospitals have been deleted through-out the proposed rule.

The rule requires a hospital to post signs in every patient room, patient care area/department and staff rest area containing information outlining the process for reporting patient safety concerns and the process for reporting unresolved concerns to the Office of Health Facility Licensure & Certification (OFLAC) and setting requirements for the signs.

West Virginia Department of Health and Human Services, Nursing Home Licensure, 64 CSR 13

The rule amends a current legislative rule. The purpose of this rule is to implement the state and federal law governing the licensing, operation, and standard of care in nursing homes located in West Virginia.

§64-13-2. Definitions.

The definition of abuse has been amended. Definitions have been added for chemical restraint, exploitation, involuntary seclusion, mental abuse, physical restraint, sexual abuse, and verbal abuse. Definitions for conviction, deemed status, deficiency, department, direct access, direct access personnel,

fitness determination, immediate jeopardy, negative finding, nursing home, restraint, secretary, and substantial compliance were deleted.

§64-13-3. State Administrative Procedures.

A new subdivision 3.1.3. adds a requirement for a licensee to notify the director if there is a special unit within the same physical environment of the nursing home, or on the same campus or premise which has a different advertised name. A separate license is unnecessary.

A new subdivision 3.2.3. provides that nursing homes certified by Centers for Medicare & Medicaid Services (CMS) under 42 CFR 483 are exempt from the provisions of this rule unless they are part of an express state requirement. Subsection 3.9 relating to availability of reports and records has been deleted.

§64-13-4. Residents' Rights.

A new subdivision 4.3.8 prohibits an employee of a nursing home or a person or his or her spouse having a financial interest in the nursing home from serving as a resident's legal representative unless the employee or person is related to the resident to the degree of a second cousin or unless the nursing home has been named temporary legal representative payee.

§64-13-5. Quality of Life.

Subdivision 5.3.6 has been amended to require residents' access to electronic communications such as access to email and video communications. A new subdivision, 5.3.7, provides that the resident has the right to personal privacy regarding accommodations, medical treatment, written communications, personal care, visits, and meetings of family.

§64-13-8. Quality of Care.

New requirements have been added addressing dosing for residents receiving antipsychotic drugs, trauma-informed care, and pain management.

§64-13-10. Administration and Human Resources.

Language regarding criminal background checks has been deleted. New language provides that all direct access personnel are subject to the provisions of the WV Clearance for Access: Registry and Employment Screening Act.

§64-13-11. Laboratory, Radiology, and other Diagnostic Services.

This section has been amended to require a facility to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges.

§64-13-14. Inspections and Investigations.

This section has been amended to give any person the right to obtain the most recent past state and federal inspection and complaint reports with the nursing home's plan of correction.

§64-13-17. Deemed Status.

This section has been deleted.

West Virginia Department of Health and Human Services, Emergency Medical Services, 64 CSR 48

The rule amends a current legislative rule. The purpose of the rule is to ensure adequate provision of emergency medical services to the residents of West Virginia to meet the purposes set out in W.Va. Code

§16-4C-2 and to provide clear direction emergency medical services personnel and agencies in West Virginia.

A new subdivision 6.2.15 requires personnel to limit bystander presence and maintain a distance of six feet from any member of the public other than patients, and to wear a face mask covering and eye protection. The section is to remain in effect until the Governor's State of Emergency of March 16, 2020, is lifted.

West Virginia Department of Health and Human Resources, Client Rights at State-Operated Mental Health Facilities, 64 CSR 59

The rule amends a current legislative rule. It applies to state-operated mental health facilities that are licensed to provide behavioral health services or inpatient psychiatric services. The rule replaces references to behavioral health with mental health throughout the rule. Numerous definitions are added or amended.

The State Operations Manual Survey Protocol is adopted by reference. With respect to a client's right to treatment provisions the requirements for the Initial Program Plan, Interim Program Plan, Individualized Program Plan, and Minimum Requirements of the Individualized Program Plan were all deleted.

Provisions regarding a patient's rights have been amended relating to a right to treatment in the least restrictive setting, detention in a mental health facility for the sole purpose of confinement, requiring care and treatment be provided by qualified personnel and staff, requiring the initial psychiatric evaluation be conducted within 60 hours of the patient's admission, development of program plans, treatment planning and discharge planning, requiring all care and treatment be provided in accordance with the applicable standard of care, physical examinations and medication, medical records, and informed consent before administration of antipsychotic medication.

Section 10 of the rule relating to seclusion and restraint were amended. Fundamentally, it states that federal regulations control. It prohibits the use of seclusion or mechanical or chemical restraints solely as a means of coercion, discipline, convenience, or retaliation. It requires all personnel who administer or assist in the administration of seclusion or the use of chemical restraint to undergo training. Handcuffs are prohibited. Requirements regarding documentation have been amended.

Section 19, relating to juveniles was amended to reflect that no person under the age of 18 may be admitted to a mental health facility.

West Virginia Department of Health and Human Resources, Delegation of Medication and Health Maintenance Tasks to Approved Medication Assistive Personnel, 64 CSR 60

The rule amends a current legislative rule. This rule sets specific standards and procedures for training, competency testing, and the certification of Approved Medication Assistive Personnel (AMAP) for the limited administration of medications and performance of health maintenance tasks in specified health facilities.

Amendments to this rule are required, in part, because of the passage of Senate Bill 560 during the 2020 Regular Session of the Legislature. This bill permitted a nursing home to use trained individuals to administer medication under the direction of a registered professional nurse.

§64-60-1. General.

A new subsection has been added that permits the department to grant a variance from any provision of the rule if it determines strict compliance would impose a substantial hardship on the licensee, the licensee will otherwise meet the goal of the rule; and a variance will not result in less protection of the health, safety, and welfare of the residents. The rule provides that the variance must be submitted in writing and to the authorizing agency.

§64-60-3. AMAP Program Approval.

This section previously related to facility administrative procedures. It now provides that any facility may permit the use of AMAP when supervised by an authorized registered professional nurse. This section of the rule also sets requires the AMAP to successfully complete training retraining and competency testing. The AMAP who have successfully trained and tested in one facility must, prior to being approved to perform AMAP tasks in another facility, be reevaluated for competency by the authorized registered nurse. The authorizing agency may contract with an entity to provide facility trainer or instructor orientation training for the authorized registered nurse. The facility using services shall pay for training and testing. This section also sets forth specific requirements for the authorized registered professional nurse. Each facility must have at least one authorized registered professional nurse. The registered professional nurse is to determine whether the resident is in stable condition relative to the tasks proposed to be delegated. Any facility that uses the program shall, upon request, make a list of AMAPs available.

This section also requires non-nursing homes with an approved AMAP program, to purchase and maintain liability insurance for the coverage of the licensed and unlicensed personnel in the delivery of the services. It provides that nothing in the rule prohibits any facility staff members from providing prudent emergency assistance to aid any person.

§64-60-5. Curriculum and Competency Evaluation.

This section sets forth the curriculum for the AMAP program and how this curriculum will be tested. The authorizing agency's training curricula is to be based upon a nationally recognized model for certified medical aides. This section provides any AMAP who successfully completed training and competency prior to the passage of this rule is exempt from the new training requirements. It also requires the prospective AMAP to pass a national medication aide certification examination offered by the National Council of the State Board of Nurses.

§64-60-6. Eligibility Requirements for AMAP to be Trained.

This section sets forth the eligibility requirements for AMAP to be trained provide the facility may permit a staff member to be trained as an AMAP. Among other criteria, a facility staff member must have at least one-year experience as a nurse aide in a long-term care facility and be certified in CPR.

§64-60-7. Policy Development and Approval Procedures.

This section provides facilities are not permitted to implement an AMAP program prior to the authorizing agency's approval of the AMAP program's policies and procedures. The rule requires the policies and procedures to be reviewed once a year. It also contains requirements for personnel records, resident medical records, medication administration records, monitoring and supervision, multiple site coverage, review of physician's orders, withdrawal of approval, communication, and a medication delivery system.

§64-60-9. Limitations on Medication Administration and Health Maintenance Tasks Approved Medication Assistive Personnel.

This section sets forth criteria for distribution of medication by the AMAP. It provides an exception for non-nursing home facilities to use prefilled insulin or insulin pens. First doses of a new medication may not be administered in a nursing home setting. Health maintenance tasks may not be delegated in nursing homes.

DHHR, Diabetes Self-Management Education, 64 CSR 115

This new rule establishes the training requirements and procedures necessary for diabetes self-management education to be provided by properly trained health care practitioners in West Virginia. It provides that all diabetics be provided the opportunity to receive diabetes self-management education. It is to be offered at diagnosis, annually or when not meeting targets, when complications occur, and during transitions in life and care. The education may be offered in a group or provided by a trained health care practitioner. The Bureau for Public Health is to maintain a current list of trained health care providers. Telehealth is permissible.

West Virginia Department for Health and Human Resources, West Virginia Clearance for Access: Registry and Employment Screening, 69 CSR 10

This rule amends a current legislative rule. The purpose is to protect West Virginia's vulnerable population by requiring registry prescreening and state and federal criminal background checks for all direct access personnel of the DHHR, covered providers, and covered contractors. Throughout the proposed rule, the Department is added to the list of direct access personnel. Lastly, the rule changes the definition for the term "Covered Provider".

West Virginia Department of Health and Human Resources, Recovery Residence Certification and Accreditation Program, 69 CSR 15

This new rule sets forth the requirements for certification and accreditation of recovery residences. A recovery residence is a single-family, drug-free, alcohol-free residential dwelling unit, or other forms of group housing, that is offered or advertised by any person or entity as a residence that provides a drug-free and alcohol-free living environment of the purposed of promoting sustained, long-term recovery from substance use disorder.

The rule requires the Bureau for Behavioral Health to appoint at least one certifying agency to administer the recovery residence accreditation programs. The appointed certifying agency must be an affiliate of National Alliance for Recovery Residences (NARR), Oxford House or a similar national entity and may last up to two years or be mutually terminated with 120 days-notice. The rule provides the monitoring of the certifying agency.

The rule sets forth minimum standards for recovery residence certification. It specifies the information to be included on a certificate of compliance, provides for the revocation and reinstatement of certification,

The rule includes a section regarding the rights and responsibilities of residents which requires each recovery residence to establish and adhere to a written policy regarding client rights and a written grievance procedure. The owner of a recovery residence has a right, under the proposed rule, to appeal the denial, suspension, or revocation of a certification and to then appeal a final decision to the Circuit Court of Kanawha County or in the county where the petitioner resides or does business. The owner may appeal the decision of the circuit court to the Supreme Court of Appeals of West Virginia.

House Bill 4620 which passed during the 2020 Regular Session of the Legislature included language specifying that the article does not permit a structure that would not normally be classified as a single-family dwelling to be exempt from the state building code or fire code.

Department of Health and Human Resources, Child Placing Agency Licensure, 78 CSR 2

The rule amends a current Legislative rule. It modernizes and updates the standards and procedures for the licensure of child placing agencies. It deletes references to initial, provisional, and regular licenses; updates from the criminal background check to the West Virginia Clearance for Access: Registry & Employment Screening (CARES) check in the foster or adoptive parent records; removes quality assurance program; requires a missing child to be reported immediately instead of within 24 hours; allows an applicant for employment to work under direct supervision once a background check has begun for no more than 60 days until the background check is completed; clarifies employee educational and training requirements; sets forth the child and his or her family's basic rights as they relate to general rights, health rights, religious preferences, multi-ethnic placements; behavior management and discipline, financial resources, and clothing.

The rule also specifies information to be included in a child's placement plan; requirements for transfers and discharges; requires the agency to inform foster or adoptive parents of the foster child bill of rights; provides that foster and adoptive parents may only be certified with one agency at any given time; requires all offenses committed by current juvenile household members to be reported on a continual basis; requires a childcare provider for a foster or adoptive family shall meet the same criteria for background checks and protective service record checks as the foster or adoptive parent or be a licensed childcare provider; prohibits an agency from denying a foster or adoptive parent a certification of approval of their home for placement on the basis of a class of individuals protected by federal or state statutes or rules; requires an annual safety assessment for each foster or adoptive parents and specifies information that must be included; requires an agency to maintain records for biological parents containing specified information; and requires a written plan for a child transitioning from foster care.

The rule eliminates the requirement that the governing board of a child placing agency implement a mission statement; removed the minimum requirements for an executive director; in addition to current qualifications, allows a person with a Bachelor's degree who has completed a department approved training program provide by the child placing agency to be employed as a case manager; removes the requirement that an employee orientation program include training in the agency's philosophy and mission; and removes the requirement an agency's procedure for emergency discharges include a provision that the child be accompanied by a designated employee to the receiving agency or individual.

Department of Health and Human Resources, Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults and vulnerable and Transitioning Youth Group Homes and Programs in West Virginia, 78 CSR 3

This rule originally established standards and procedures for the licensure of residential childcare and treatment facilities. It has been amended to include the addition of vulnerable and transitioning youth group homes and programs. The proposed rule: Removes annual time study of the quantification of employee supervision time; removed requirement that mission statement and long term plan be in the administrative file; removes specific insurance requirements; requires that contracted services be certified or licensed in the service they are providing; require that a contracted licensed practitioner who serves children in his or her own location is licensed in the service he or she is providing; and removes some required hiring and training practices.

The rule requires program employees with direct care responsibilities to be trained within 90 days of employment on the following: sensitivity to differences in cultural norms and values as appropriate; management of children attempting to escape supervision or who are away from supervision; sensitivity to sexual identity including lesbian, gay, bisexual, transgender and questioning youth; family dynamics, including human growth and development; proper documentation techniques; basic therapeutic or behavior management techniques; and food handler's certification as necessary and appropriate. Program employees with direct care responsibilities must also be trained within 90 days of employment on children's trauma stress experiences, to include: impact on development, behavior, and relationships; understanding the types of trauma; understanding the influence of cultural factors; recognizing how ongoing stressors impact child traumatic stress; responding to crises with interventions; and strategies and interventions to promote resiliency and health. Employees must be trained at the time of admission to serve any child with special needs. All employees shall be trained on prudent parenting standards and on interacting with victims of sex trafficking. The organization must document all employee training provided to employees, including a survey by the employee that indicates that he or she feels adequately trained to do their job.

A child entering a facility with properly bottled and labeled medications may continue on those medications with appropriate consents, until such time as the organization can obtain current physician's orders, either from the organization's physician or the child's physician, to continue the medications. Currently there is a 72-hour limitation. In the case of all other prescribed medication, the guardian must be notified within one business day of the medication prescribed, the reason, and the date the medication began.

The rule requires that prior to discharge, the team shall meet to review and document the child's progress in treatment, describe continuing problems and issues, and develop specific recommendations for aftercare and follow-up. The aftercare and follow-up plans or recommendations must be provided to the child and his or her parent and guardian upon discharge.

Under the rule, when the initial assessment indicates the presence of a sexually sensitive history (either as offender or victim) the organization must consider the child's history when making determination regarding housing and supervision in order to ensure the safety of all the children. The organization must also ensure that discharge plans make provisions for clothing needs at the time of discharge. All personal clothing shall go with a child when he or she is discharged, or arrangements shall be made if the child was not able to leave with his or her personal belongings. The organization must provide a list of items that are not appropriate for the child to have at the program upon intake.

Section 26 relating to vulnerable and transitioning youth group homes and programs is new and exempts them from numerous sections of the proposed rule. It specifies programs, procedures, and policies the organization must develop and make available to employees and residents. These include a complete and detailed description of the range of services offered and eligibility requirements for admission; specific service training to employees providing transitional living services prior to their direct work with youth; programming to provide sex trafficking prevention; assessment of a youth's health and medical needs that ensures that any youth receives appropriate health screening and services, including medical and dental screening and services; and the determination of the appropriateness for living arrangements used for offsite transitional living.

The organization must also provide a process for developing appropriate aftercare or discharge plans for youth and specifies what those plans must contain. In addition, the process for serving individuals with

developmental disabilities with supportive services to help them fully interact with the community and achieve maximum independence and a detailed youth's case record is to be developed.

The rule removes the specific policy and procedure requirements for developing a process for assessing and improving overall performance; removes types of allowable governing bodies, struck the section related to performance review, removed the criteria for adjusting supervisory ratios for program employees, deleted specific provisions on environmental quality and inserted in lieu thereof a requirement that an organization meet all applicable federal, state, and local health, building, safety and fire codes, deleted specific food services standards and instead referenced local health department regulations relating to food services, and deleted provisions regarding compliance with legal, health and regulatory requirements.

Human Services, Procedure to Contest the Substantiation of Child Abuse or Neglect, 78 CSR 27

This new rule establishes the procedure to contest a substantiation of abuse or neglect determined by a Child Protective Services (CPS) worker as required by House Bill 4092 passed during the 2020 Regular Session of the Legislature. It requires the Bureau of Human Services to provide written notice to the maltreater that through an assessment or investigation that he or she has had an allegation of abuse or neglect substantiated. It specifies the information which must be required in the notice. The notice must contain information concerning a person's right to grieve the substantiation of abuse before the Board of Review; information on the ability to discuss the case with a supervisor; clear instructions on how to file a grievance with time limits; the right to request a copy of the file; and the right to appeal the decision of the Board of Review.

The rule does not contain a provision requiring the Department to remove a person's name from an abuse and neglect registry if substantiation is successfully challenged as required by House Bill 4092.

The rule specifies what is necessary for the Department to substantiate a claim of abuse or neglect and provides notice and grievance procedures and requires non-substantiated claims be recorded as such in the Bureau's records.

Health Care Authority, Exemption from Certificate of Need, 65 CSR 29

The purpose of this rule is to implement House Bill 4108, which passed during the 2020 Regular session and eliminated the \$1,000 application fee for review of exempt health care services. The Health Care Authority reviews the application information to ensure compliance with the requirements of the exemption. Language has also been deleted; prohibiting the affected party from filing an objection to the exemption request; prohibiting an administrative hearing to review the application; setting time frames for action by the Authority. The rule eliminates the review of exemption requests by the Health Care Authority.

CODE REFERENCE: West Virginia Code §64-5-1 et seq. – amended

DATE OF PASSAGE: April 6, 2021

EFFECTIVE DATE: April 6, 2021

ACTION BY GOVERNOR: Signed April 28, 2021

House Bill 2616

Amend the reporting to the Governor and the Legislature to have information continuously available on the Office of Health Facility Licensure and Certification's website

The bill revises definitions for Director to mean the Director of the Office of Health Facility Licensure and Certification rather than the director of the Division of Health. The definition of Division is revised to mean the Office of Health Facility Licensure and Certification and not the division of health of the state department of health and human resources. With respect to the powers and duties section, the director may propose various rules and make available, at all times, through the OHFLAC web page information regarding the residential care community licensing and investigatory activities of the division.

CODE REFERENCE: West Virginia Code §16-5N-2 and §16-5N-3 – amended

DATE OF PASSAGE: March 19, 2021

EFFECTIVE DATE: June 17, 2021

ACTION BY GOVERNOR: Signed March 30, 2021

House Bill 2776

Creating the Air Ambulance Patient Protection Act

This bill allows the Offices of the Insurance Commissioner to regulate and license the sale of air ambulance membership services, to the extent that those services promise to reimburse or indemnify costs of a member's air ambulance transport.

CODE REFERENCE: West Virginia Code §31-11B-1 through §31-11B-7 – new

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Signed April 28, 2021

House Bill 2877

Expand direct health care agreements beyond primary care to include more medical care services

The purpose of this bill is to expand direct health care agreements beyond primary care to include more medical care services, such as physical therapy.

CODE REFERENCE: West Virginia Code §30-3F-1, §30-3F-2 and §30-3F-3 – amended

DATE OF PASSAGE: April 5, 2021

EFFECTIVE DATE: July 4, 2021

ACTION BY GOVERNOR: Signed April 19, 2021

House Bill 2905

Unlawful use of prefix “Doctor” or “Dr.” penalty

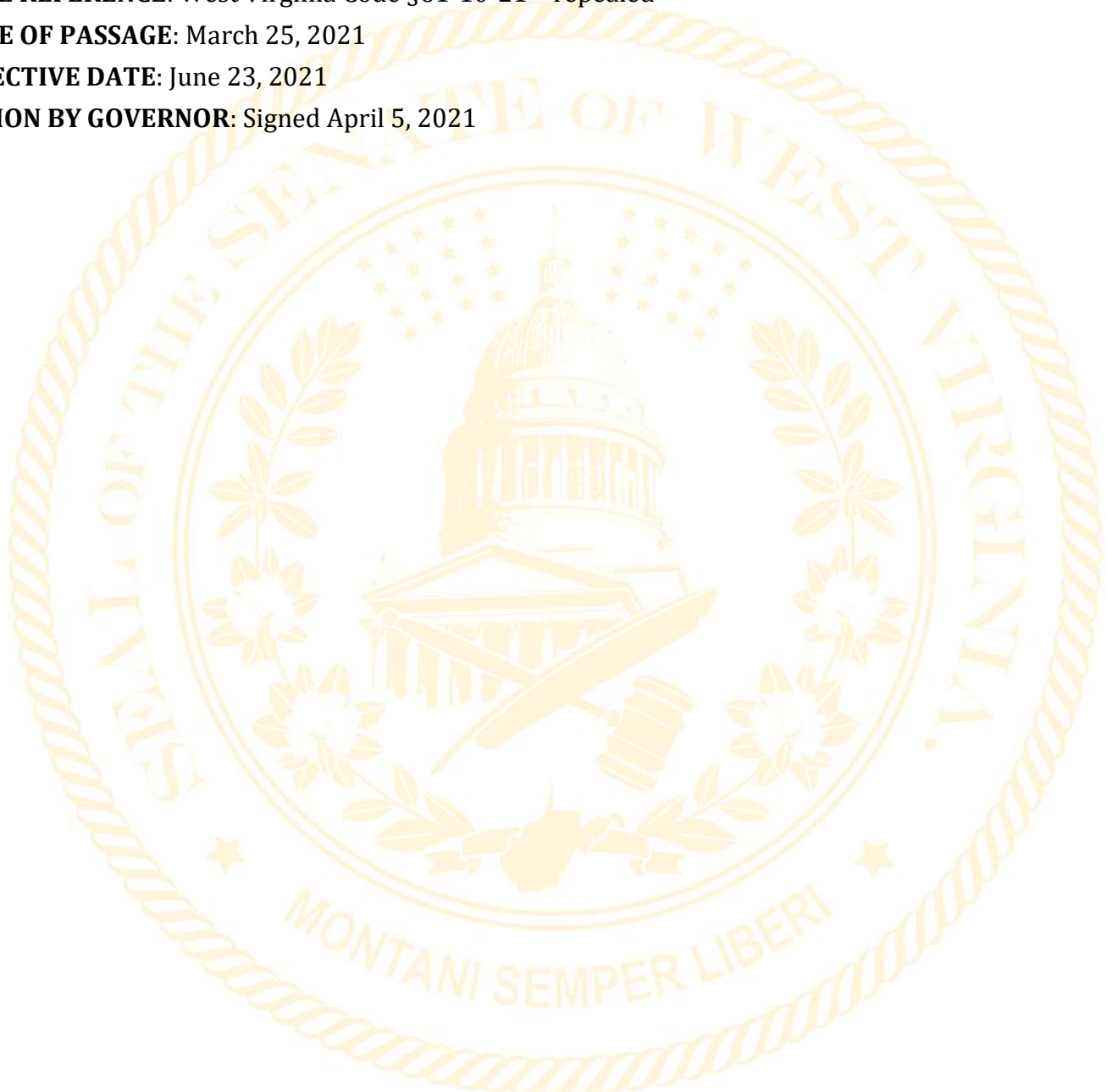
The purpose of this bill is to repeal the prohibition against the use of the word “Doctor” or prefix “Dr.” in connection with his or her name in any letter, business card, advertisement, sign, or public display of any nature without affixing suitable words or letters designating the degree he or she holds.

CODE REFERENCE: West Virginia Code §61-10-21 – repealed

DATE OF PASSAGE: March 25, 2021

EFFECTIVE DATE: June 23, 2021

ACTION BY GOVERNOR: Signed April 5, 2021



House Bill 2962

Relating generally to dental practice

With respect to the license to practice dentistry, the bill removes a requirement that an applicant be of good moral character and substitutes in its place that an applicant does not have a criminal conviction which would bar the applicant's licensure and in order to be licensed meets the other requirements as specified by rule. The bill removes language related to demonstrating competency in the area of periodontics and restorative dentistry in a patient based clinical setting.

With respect to the license to practice dental hygiene, the bill removes a requirement that an applicant be of good moral character and substitutes in its place that an applicant does not have a criminal conviction that would bar the applicant's licensure and in order to be licensed meets the other requirements as specified in the rule.

The bill requires any person regulated by this article to conspicuously display his or her board authorization at his or her place of practice. The place of practice is new language and replaces "business location."

With respect to special volunteer dentist or dental hygienist license, a technical change is made to this language. The bill clarifies that a clinic organized for the delivery of health care without charge is not relieved from imputed liability for the negligent acts of a dentist or dental hygienist rendering voluntary "uncompensated" rather than "dental hygiene" care. With respect to issuing a volunteer license, the bill removes a statement that the dentist placed their license in inactive status in lieu of having a complaint initiated.

With respect to dental corporations, the bill permits a professional limited liability corporation to be formed.

The bill clarifies that reinstatement involving a mental evaluation shall be paid at the expense of the requestor. This evaluation is at the discretion of the board. This section strikes a reference to impairment of drugs or alcohol.

There is a section regarding complaints, investigations, and grounds for disciplinary action that is revised. It revised the crimes section and related it to a crime related to the practice of dentistry. This section strikes language related to moral turpitude.

This same section strikes language related to advertising or offering soliciting subscriptions from individuals as a grounds for discipline.

The bill adds administering sedation anesthesia without a permit or other violation of the code and failing to observe or adhere to regulations, standards or guidelines regarding infection control otherwise applicable to dental care settings as grounds for discipline.

The bill provides strikes the existing criminal offenses section and adds language to state that any person who practices dentistry or dental hygiene in the state and has never been licensed, hold a license that has been inactive, revoked, or suspended as a result of disciplinary action or surrendered to the board is guilty of a felony and upon conviction shall be fined not more than \$10,000 or imprisoned for not less than one year nor more than five years.

The bill also provides that any person who hold himself or herself out as a dental hygienist and has never been licensed, hold a license that has expired or lapsed or hold a license that has been inactive,

revoked or suspended as a result of disciplinary action is guilty of a misdemeanor and shall be fined not more than \$5000 or confined in jail not more than 12 months.

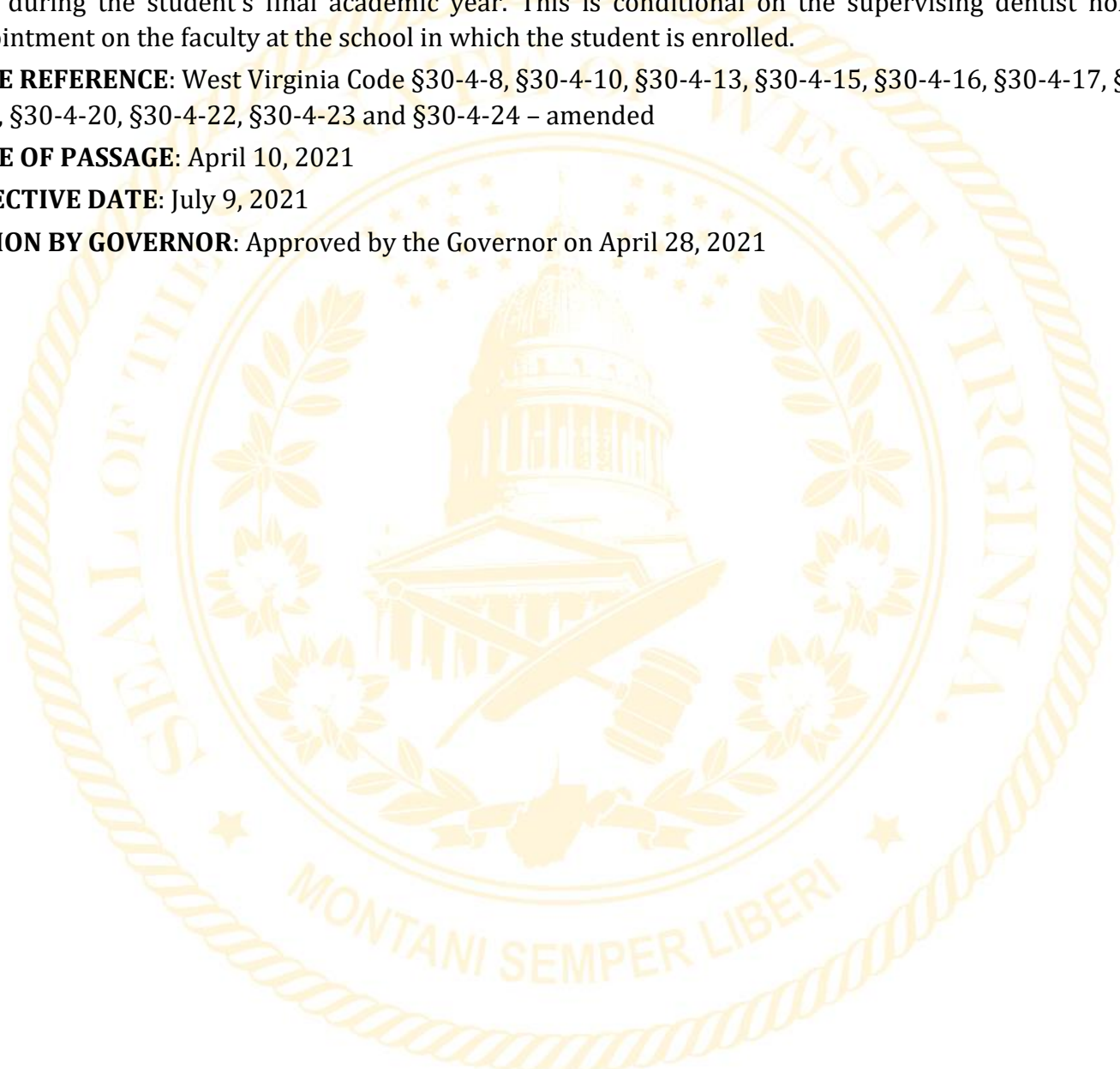
The bill also provides that a student enrolled in an accredited DDS or MD degree program or an accredited dental hygiene program practicing under the direct supervision of an instructor licensed by the board and within a school, college, or university in this state, in a dental clinic operated by a non profit organization providing indigent care, in a governmental or indigent care clinic in which the student is assigned to practice during his or her final academic year rotations or in a private dental office for a limited time during the student's final academic year. This is conditional on the supervising dentist holding appointment on the faculty at the school in which the student is enrolled.

CODE REFERENCE: West Virginia Code §30-4-8, §30-4-10, §30-4-13, §30-4-15, §30-4-16, §30-4-17, §30-4-19, §30-4-20, §30-4-22, §30-4-23 and §30-4-24 – amended

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Approved by the Governor on April 28, 2021



House Bill 2982

Relating to the Second Chances at Life Act of 2021

The bill defines terms by referencing other code sections. Abortion is defined by referencing §16-2F-2 which means the use of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a female known to be pregnant and with intent to cause the expulsion of a fetus other than by live birth. This does not prevent prescription, sale, or transfer of IUD devices or other contraceptive devices, or other generally medically accepted contraceptive devices, instruments, medicines, or drugs for whom the drugs, contraceptive devices, instruments, medicines, or drugs were prescribed by a physician.

“Attempt to perform an abortion” is defined as an act or an omission of a statutorily required act that under the circumstances as the person believes them to be, constitutes a substantial step in a course of conduct planned to culminate in the performance or induction of an abortion in this state in violation of the applicable provisions of this code.

“Chemical abortion” is a new term, meaning the use or prescription of an abortion- inducing drug dispensed with the intent to cause an abortion.

The bill applies to a “licensed medical professional”, which means a person licensed under Chapter 30.

A “medical emergency” is defined as a condition that based on reasonable medical judgment of the patient’s physician, so complicates the medical condition of a pregnant female that it necessitates the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions. No conditions shall be deemed a medical emergency if based on a claims or diagnosis that the female will engage in conduct which she intends to result in her death or in substantial harm and irreversible physical impairment of a major bodily function.

The definition of “physician” means a person with an unrestricted license to practice allopathic medicine pursuant to Chapter 30.

The term “reasonable medical judgment” means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities.

The bill adds additional information to the informed consent portion of the law. It requires if a chemical abortion involving the two-drug process of mifepristone is initiated and then a prostaglandin such as misoprostol is planned to be used later the female shall be informed that:

- Some suggest that it may be possible to counteract the intended effect of a mifepristone chemical abortion by taking progesterone if the female changes her mind, before taking the second drug, but this process has not been approved by the Food and Drug Administration.
- After the first drug involved in the two-drug process is dispensed in a mifepristone chemical abortion, the physician shall provide written medical discharge instructions to the pregnant female which shall include the statement:
 - “If you change your mind and decide to try to counteract the intended effects of a mifepristone chemical abortion, if the second pill has not been taken, please consult your physician. You might experience a complete abortion without ever taking misoprostol; You might experience a missed abortion, which means the fetus is no longer viable, but the fetus did not leave your body; or It is possible that your pregnancy may continue; and You should consult with your physician.”

The bill requires the female to certify, as part of the informed consent process, that she has been informed of these possibilities.

The bill contains waiver of liability language for a physician complying with the informed consent provisions of this section and prescribing a non-FDA approved drug to counteract a chemical abortion.

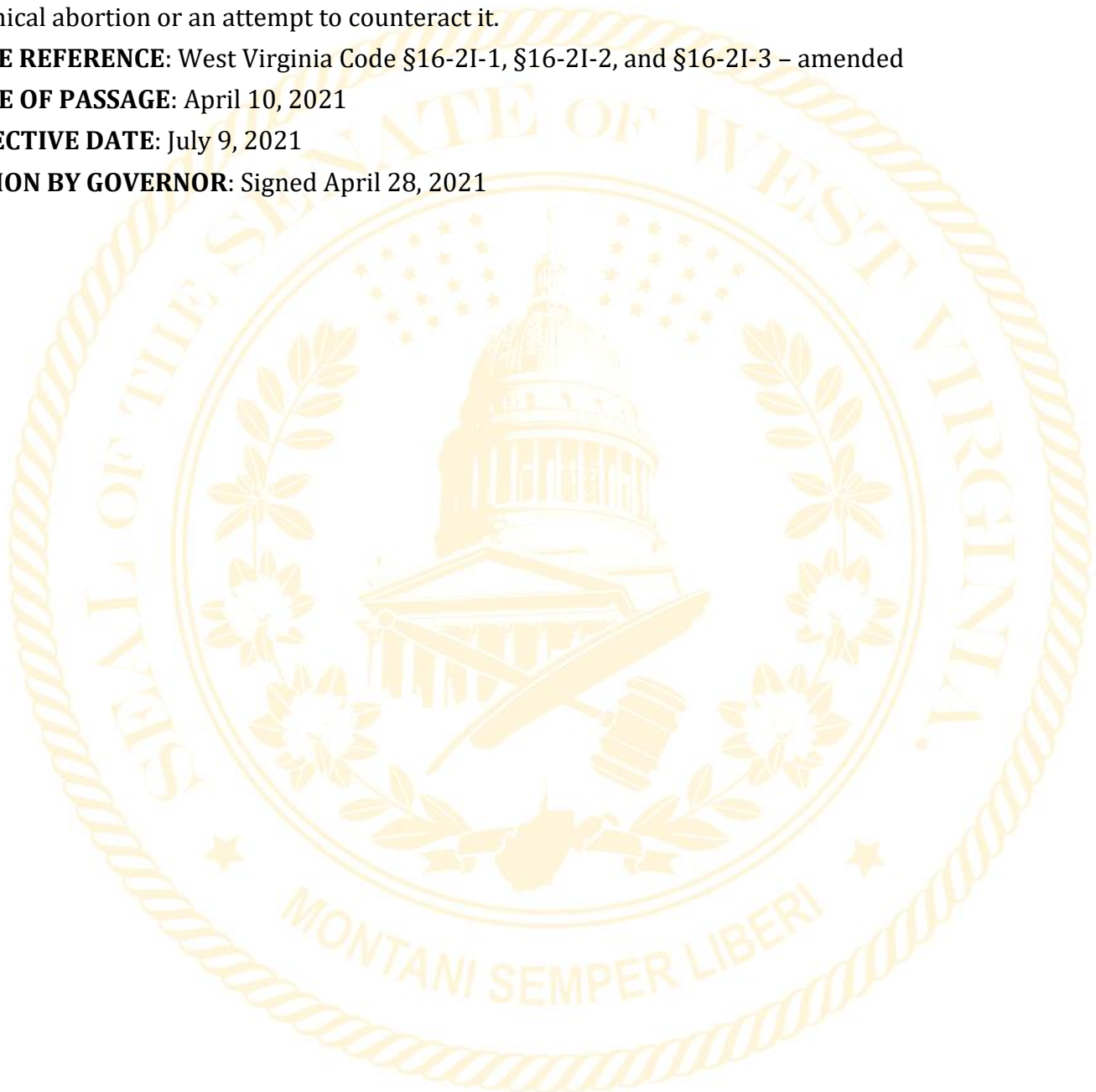
The bill requires the Secretary of the Department of Health and Human Resources to print materials designed to inform the female of the range of possibilities regarding the effects and risks of a mifepristone chemical abortion or an attempt to counteract it.

CODE REFERENCE: West Virginia Code §16-2I-1, §16-2I-2, and §16-2I-3 – amended

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: July 9, 2021

ACTION BY GOVERNOR: Signed April 28, 2021



House Bill 3045

Relating to firefighter disability claims

The bill amends one section in the Workers' Compensation chapter of the West Virginia Code, covering disability and death benefits. The bill deletes the sunset date of July 1, 2023, of a rebuttable presumption in worker's compensation law that provides that a professional firefighter who has developed leukemia, lymphoma, or multiple myeloma has contracted such cancer in the course of his or her employment, meaning it is assumed to be a disease compensable under worker's compensation. Such sunset date and presumption was put into law in 2018 (Senate Bill 82, 2018).

The effect of this bill is to delete the end date for the rebuttable presumption that provides that a professional firefighter who has developed leukemia, lymphoma, or multiple myeloma is presumed to have developed such cancer in the course of his or her employment as a firefighter if:

- The person has been actively employed by a first department as a professional firefighter for a minimum of two years prior to the cardiovascular injury or onset of a cardiovascular or pulmonary disease,
- The injury or onset of the disease or death occurred within six months of having participated in firefighting or training or drill exercise which actually involved firefighting;
- In the case of leukemia, lymphoma, or multiple myeloma the person has been actively employed by a fire department as a professional firefighter for a minimum of five years in the state prior to the development of leukemia, lymphoma, or multiple myeloma, has not used tobacco products for at least 10 years and is not over the age of 65 years.

Current law also provides that when the above conditions are met, it shall be presumed that sufficient notice of the injury, disease, or death has been given and that the injury, disease, or death was not self-inflicted.

CODE REFERENCE: West Virginia Code §23-4-1 – amended

DATE OF PASSAGE: April 5, 2021

EFFECTIVE DATE: July 4, 2021

ACTION BY GOVERNOR: Signed April 26, 2021

House Bill 3107

Declaring that Post Traumatic Stress Disorder diagnosed by a licensed psychiatrist is a compensable occupational disease for first responders

The bill provides an exception to the general workers' compensation law that excludes compensation for non-physical injuries causing non-physical injuries, known as mental-mental claims.

The bill defines terms such as first responder, post-traumatic stress, licensed mental health provider, and employer.

The bill states that a post-traumatic stress disorder suffered by a first responder may be recognized as compensable occupational disease when (1) the Employer has elected to provide coverage for post-traumatic stress disorder as an occupational disease; and (2) A diagnosis has been made by a licensed psychiatrist that the first responder suffered from post-traumatic stress disorder due to exposure to an event or events that occurred in the course of and resulting from the first responder's paid or volunteer covered employment. These sections apply only to a post-traumatic stress disorder diagnosis made on or after July 1, 2021, or the first day of the employer's next workers' compensation insurance policy or self-insurance program term for which post-traumatic stress disorder coverage has been purchased or elected whichever is later.

Mental health treatment may be offered by a licensed mental health provider other than the diagnosing psychiatrist.

A diagnosis of post-traumatic stress disorder shall not include consideration of layoff, termination, disciplinary action, or any similar personnel-related action taken in good faith by an employer.

The receipt of benefits is contingent on a claim being made within three years from and after a licensed psychiatrist has made the claimant aware of a post-traumatic stress disorder diagnosis in accordance with this section.

An employer that elects coverage shall report claims data to the Offices of the Insurance Commission beginning July 1, 2021.

The Insurance Commissioner shall report claims to the Joint Committee on Volunteer Fire Department and Emergency Medical Services beginning January 1, 2022.

CODE REFERENCE: West Virginia Code §23-4-1f – amended

DATE OF PASSAGE: April 10, 2021

EFFECTIVE DATE: April 10, 2021

ACTION BY GOVERNOR: Signed April 21, 2021

House Bill 3311

Relating to the cost of medical records

The bill states that a provider may charge a patient or the patient's representative no more than a fee consistent with HIPAA for health care records.

The bill has been reorganized to reflect that existing (b) and (c) apply to persons other than patients or patient's personal representative requesting medical records.

CODE REFERENCE: West Virginia Code §16-29-2 – amended

DATE OF PASSAGE: April 9, 2021

EFFECTIVE DATE: July 8, 2021

ACTION BY GOVERNOR: Signed April 26, 2021



2021 Third Extraordinary Session

House Bill 3026

Relating to review, approval, disapproval, or amendment of local boards of health rules by county commission or county board of education

This bill is to clarify Senate Bill No. 12 which was adopted during the 2021 Legislative Session. That bill required rules adopted by local health departments be approved, disapproved, or amended and approved by a County Commission or other appointing entity within 30 days of approval by a local board of health.

The bill clarifies a number of terms, including:

- Enforcement Activity;
- Health Order;
- Imminent public health emergency;
- Guidance;
- Local health department rule;
- Local rule; and
- State rule.

The bill also clarifies that the appointing entity must approve a local health rule or it is void if no action has been taken on a rule within thirty days. Rules in effect on March 4, 2021, are not subject to approval by an appointing authority.

It also clarifies the authority of the local health officer by altering the purview of the local health officer to include performing enforcement activities, guidance, and issue health orders.

CODE REFERENCE: West Virginia Code §16-2-11 and §16-2-13 – amended

DATE OF PASSAGE: October 15, 2021

EFFECTIVE DATE: From passage

ACTION BY GOVERNOR: Signed October 20, 2021

2020 Regular Session



Senate Bill 269

Establishing advisory council on rare disease

The bill establishes an advisory council on rare diseases. A rare disease is defined as any disease which affects fewer than 200,000 people in the US and is known to be substantially under diagnosed and unrecognized as a result of a lack of adequate diagnostic and research information, including diseases known as orphan diseases.

The council will consist of 12 members. One member is the Secretary of DHHR or designee. The remainder of the members are appointed by the Governor as follows: 3 physicians licensed and practicing in the state with experience researching, diagnosing or treating rare diseases; 3 persons over the age of 18 who either have a rare disease or are a family member of a person with a rare disease; a registered nurse or advanced practice registered nurse licensed and practicing in the state with experience treating rare diseases; a person with an advanced degree in public health or other health related field; and 3 representatives from a patient-based organization or advocacy group for rare disease. The President of the Senate and Speaker of the House serve on the council as advisory members. Members serve without compensation. Travel expenses may only be reimbursed if travel is related to activities provided for under a granted or private donation.

Duties of the council include but are not limited to: coordinating statewide efforts for the study of the incidence of rare disease within the state; research and identify priorities relating to the quality of and access to treatment and services provided to persons with rare diseases in the state; advise, consult and coordinate with other agencies of the department and patient centered organizations in the development of information and programs of benefit to the public and the health care community relating to the diagnosis, treatment and awareness of rare diseases.

The council shall report to the Governor, Secretary and WV Legislature by January 1, 2021 and annually thereafter on the activities of the council including any recommendations for statutory changes.

The DHHR Secretary may in his or her discretion provide the advisory council with administrative support. The Secretary may make and sign any agreements and may do act that are necessary to receive, accepts, or secure, grants and bequests, of funds in the name of the advisory council. A fund is created to receive grants, bequests, and gifts.

CODE REFERENCE: West Virginia Code §16-5AA-1 through §16-5AA-6 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 288

Relating to family planning and child spacing

This bill increases access to women who select long-acting reversible contraceptives. Multiple office visits with a medical practitioner are prohibitive before they are given the contraceptive. It states that the Bureau of Public Health is responsible for payment, insertion, maintenance, removal, and replacement.

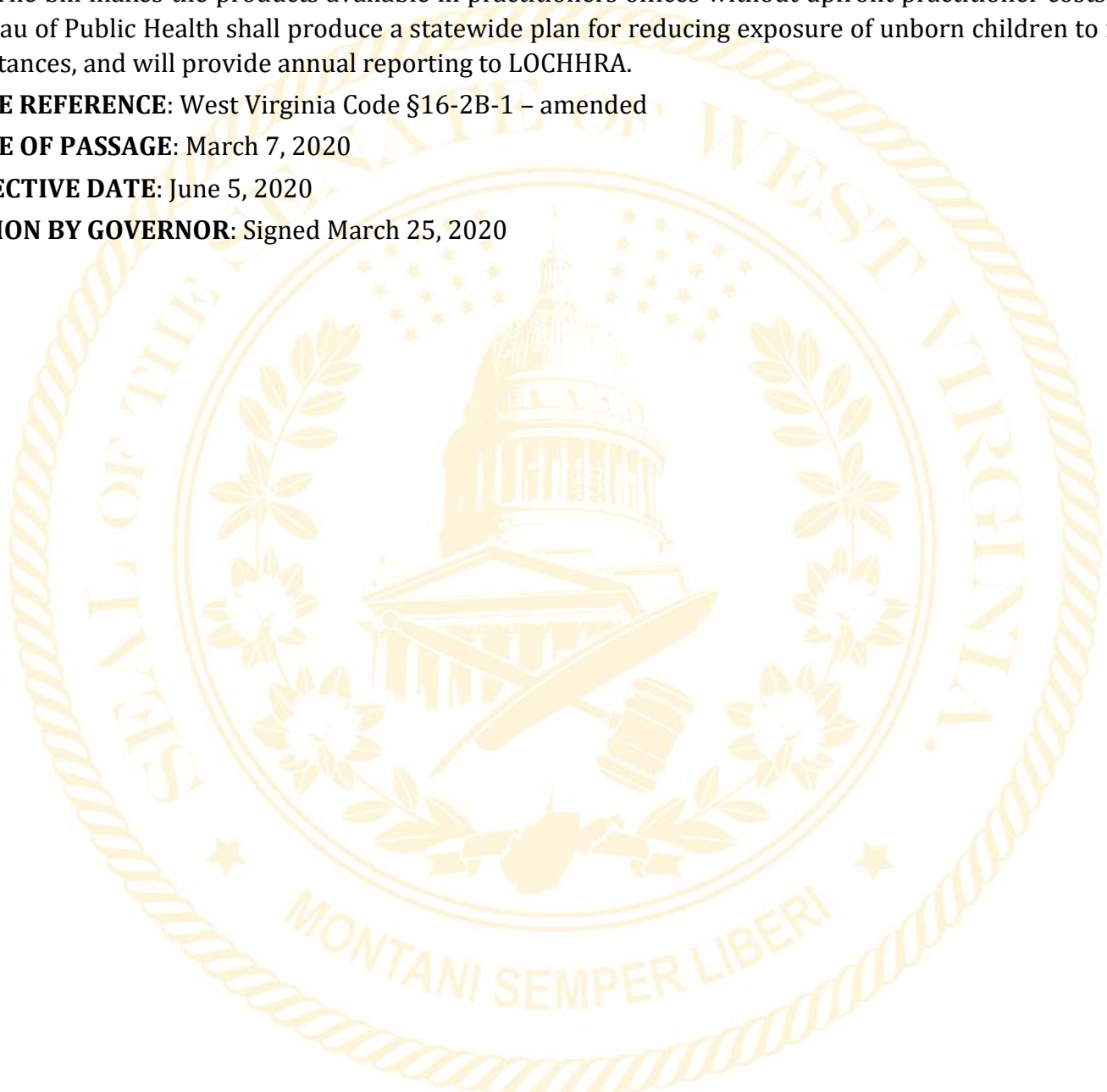
The bill makes the products available in practitioners offices without upfront practitioner costs. The Bureau of Public Health shall produce a statewide plan for reducing exposure of unborn children to illicit substances, and will provide annual reporting to LOCHHRA.

CODE REFERENCE: West Virginia Code §16-2B-1 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



Senate Bill 291

Requiring PEIA and health insurance providers provide mental health parity.

The purpose of this bill is to ensure mental health parity among the various types of insurance plans offered in West Virginia.

The bill defines the terms behavioral, mental health and substance use disorder. These are defined as a condition or disorder regardless of etiology that may be the result of a combination of genetic and environmental factors that falls under any of the diagnostic categories listed in the mental disorders section of the international statistical classification of diseases, the diagnostic and statistical manual of mental disorder or the diagnostic classification of mental health and developmental disorders of infancy and early childhood and includes autism spectrum disorder.

The Public Employees Insurance Agency and the enumerated insurance carriers are required to:

- Include coverage for behavioral health screenings with coverage and reimbursement no less extensive than coverage and reimbursement for the annual physical examination;
- Comply with nonquantitative treatment limitations requirements specified in federal regulations and precludes PEIA and the carriers from applying nonquantitative treatment limitations to behavioral health, mental health or substance use disorder that do not apply to medical and surgical benefits;
- Comply with financial requirements and quantitative treatment limitations in federal regulations and preclude carriers from applying quantitative limitations to behavioral health, mental health or substance use disorder that do not apply to medical and surgical benefits;
- Not apply any nonquantitative treatment limitations to benefits to behavioral health, mental health, and substance abuse that are not applied to medical and surgical benefits within the same class of benefits;
- Establish procedures to authorize treatment with a nonparticipating provider if a service is not available-network adequacy issues; and
- Authorize payment at the same rate used to pay for medical and surgical benefits.

The bill provides that coverage for behavioral health, mental health and substance use disorder will continue while a claim is under review until PEIA or the insurance carriers notify the covered person of the determination of the claim.

- The bill provides that unless the claim is denied for nonpayment of premium, a denial for reimbursement for the prevention of, screening for, or treatment of behavioral, mental health or substance use disorder by PEIA and the insurance carriers must include the following language:
- A statement explaining that covered persons are protected under this section, which provides that limitations placed on the access to mental health and substance use disorder benefits may be no greater than any limitations on access to medical and surgical benefits;
- A statement providing information about the Consumer Services Division of the Insurance Commissioner; and
- A statement that persons are entitled to a copy of the medical necessity criteria for any behavioral health, mental health, and substance use disorder.

The bill requires that PEIA and the Insurance Commissioner submit a parity report to the Joint Committee on Government and Finance. The report will be submitted June 21, 2021, and it will only be submitted in any year thereafter if significant changes on how they design and apply medical management

protocols. The report contains data to demonstrate parity compliance, medical necessity criteria used in determining benefits for behavioral health, mental health, and substance use disorder and the medical necessity in determining medical and surgical benefits. The report will also include identification of all nonquantitative treatment limitations that are applied to benefits for behavioral, mental health and substance use disorder and to medical and surgical benefits within each classification of benefits.

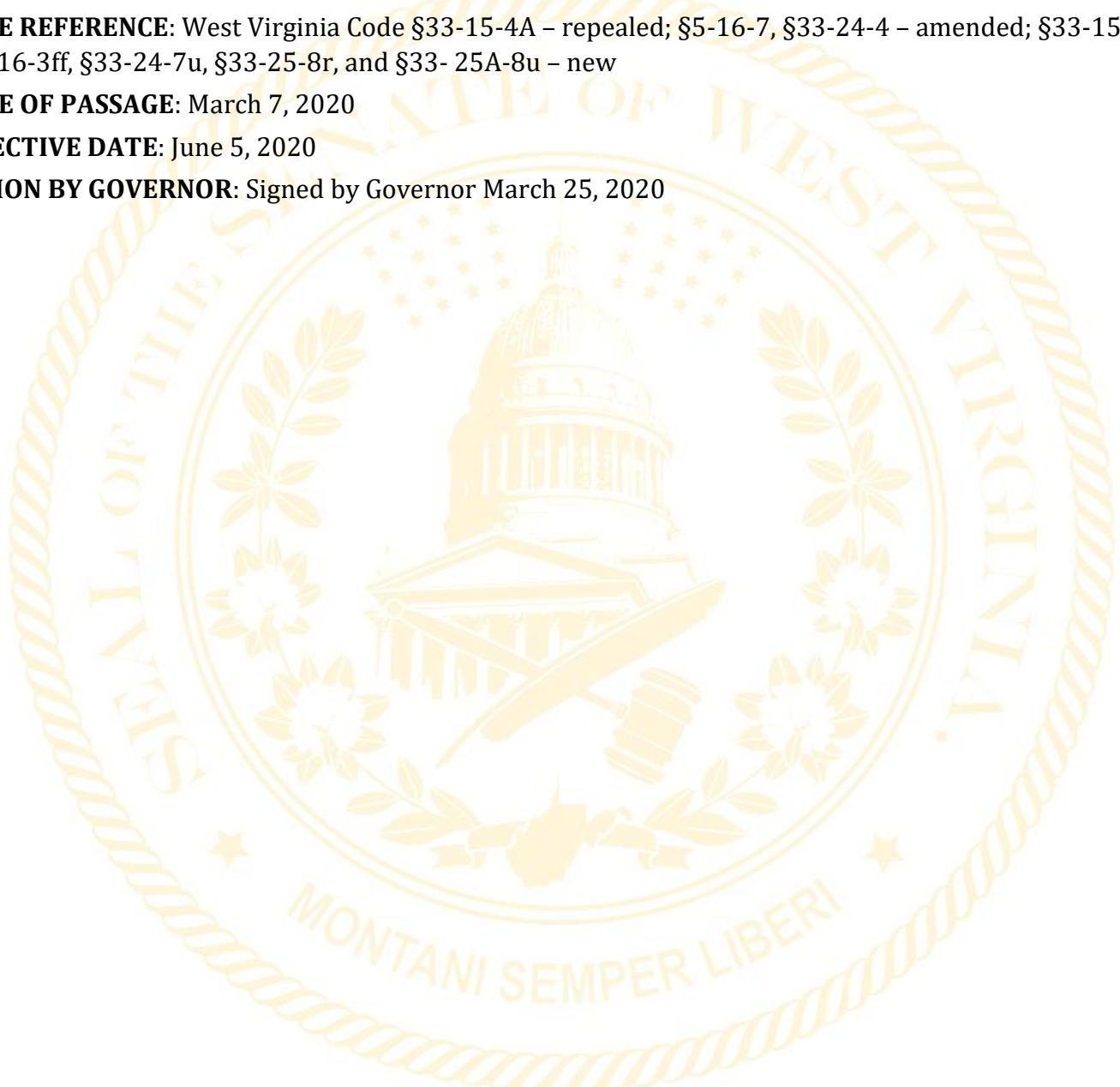
The bill provides that the Insurance Commission shall adopt legislative rules to implement the provisions of this bill and provides for an effective date of January 2, 2021.

CODE REFERENCE: West Virginia Code §33-15-4A – repealed; §5-16-7, §33-24-4 – amended; §33-15- 4u, §33-16-3ff, §33-24-7u, §33-25-8r, and §33- 25A-8u – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed by Governor March 25, 2020



Senate Bill 312

Relating to provisional licensure of social workers

The bill creates an exemption from licensure for individuals registered and creates a registration process for DHHR service workers. This would include CPS workers, APS worker, Youth Service workers, homefinders, and adoption workers. The bill adds language regarding continuing education requirements for registered workers. There is a total of 20 hours of continuing education required every two years. The language added requires at least two of the hours must be in the code of ethics adopted by the board and at least two hours shall be related to social, health and mental health concerns of veterans and their families.

The bill additionally permits the social work board to promulgate emergency rules regarding provisional licenses.

The bill leaves in a provision allowing until 2022 for a provisional worker to convert their license but clarifies the language surrounding this provision. It applies to workers that have taken the department provided courses previously allowed. The bill provides that if the individual cannot or desires not to complete this process, he or she is eligible for registration.

CODE REFERENCE: West Virginia Code §30-30-16, §30-30-18 – amended; §30-30-30 – new

DATE OF PASSAGE: March 6, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

Senate Bill 339

Authorizing Department of Health and Human Resources promulgate legislative rules

This bill is known as the Department of Health and Human Resources Rules bundle, which authorizes and directs the promulgation of 16 rules, constituting Bundle 5. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health and Human Resources, Vital Statistics, 64 CSR 32

The rule amends a current legislative rule. This rule governs the installation, maintenance, and operation of the single system of vital statistics operated throughout the state pursuant to W. Va. Code §16-5-1 et seq. The rule provides for a missing allowance for hardship cases, provides guidance for the creation of birth certificates for safe-haven babies, and sets forth specifications for paper used to create certified documents.

The rule provides that in the creation of birth certificates for safe-haven babies, the birth to be registered shall be filed at the direction of the State Registrar; requires a hospital or institution to assist in the preparation of a death certificate; provides for the disposition of bodies in deaths that have been referred to the West Virginia Office of Chief Medical Examiner (OCME), that have been determined to be outside of the purview of the OCME, when the attending physician or other medical certifier is unavailable to allow for removal or final disposition of the body within a time period to prevent undue hardship to the family; and adds a security provision that specifies that the security paper used to create certified documents must be obtained from a company in the United States or Canada and that the paper must be printed in the United States or Canada.

Department of Health and Human Resources, Emergency Medical Services, 64 CSR 48

The rule amends a current legislative rule. The purpose of this rule is to ensure the adequate provision of emergency medical services to the residents of West Virginia, to meet the purposes set forth in W. Va. Code §16-4C-1 et seq., and to provide clear direction to emergency medical services (EMS) personnel and agencies in West Virginia. The rule makes changes to certification classifications and methods for obtaining certification and makes technical changes.

The Commissioner of the Bureau of Public Health has oversight of the Office of Emergency Medical Services (OEMS). The Emergency Medical Services Advisory Council is created to assist the Commissioner regarding the maintenance of adequate emergency medical services for all portions of the state. Based on Task Force recommendations and approval by the Commissioner for the Bureau for Public Health in 2018, the Advanced Care Technician (ACT) certification will become the Advanced Emergency Medical Technician (AEMT) certification. This rule is amended to reflect that change throughout.

Also, prior to 2019, EMS personnel could obtain certification by completing an approved course and testing with the National Registry or the West Virginia State Pathway. The State Pathway is now retired and the only method to obtain state certification is by taking the NREMT test and maintaining a continuous NREMT certification. The rule is amended to reflect this new method of certification and the requirements for obtaining the certification. Additionally, the rule relies upon fingerprint identification for background checks and eliminates other methods of positive identification.

Department of Health and Human Resources, Primary Care Support Program, 64 CSR 70

The rule amends a current legislative rule. The purpose of the rule is to set forth the process for the administration of the primary care support program and to detail the administration of uncompensated

care funds. This amendment is required as a result of the passage of Senate Bill 641, which amended W.Va. Code §16-2H-2 during the 2019 Regular Session.

The purpose of Senate Bill 641 is to convert the existing revolving loan fund to a grant program for federally qualified health centers (FQHC) and federally qualified look-alikes in order to secure federal medical assistance percentage (FMAP) funding. Senate Bill 641 provides that FQHC look-alikes already receiving funding at the time this program is created shall continue to receive funding annually. Upon approval of the Secretary of DHHR, FQHCs in need of immediate financial assistance may be granted funding annually. All funds designated to federally designated qualified health centers may be transferred to Medicaid for the purpose of securing federal funding. The statute also provides that the Secretary may use “certain portions of funds within this account for activities in support of rural and primary care.”

The rule states that upon enactment and approval of the annual state budget, the Secretary shall designate a portion of the fund for transfer to the Bureau of Medical Services (BMS) medical services fund for use in the state Medicaid program in an amount the Secretary determines would be best dedicated to provide additional funding to FQHC's. The portion of the annual appropriation remaining in the primary care support fund after the transfer to BMS shall be disbursed by the Director in accordance with the rule.

The rule provides that a look-alike, rural health clinic, or other primary care center is eligible for funding if certain specified criteria are met.

The rule sets forth eligible activities: activities relating to rural and primary care, activities to offset the costs of uncompensated care provided by primary care centers, technical support to and educational collaboration with the primary care centers, required cost sharing and matching of key federal grants, and personnel and related administrative costs.

The rule provides that the grant application process only applies to the review of uncompensated care requests.

Department of Health and Human Resources, Medical Cannabis Program Dispensaries, 64 CSR 112

The rule establishes the regulations for the certification and operation of medical cannabis dispensaries. It defines terms and requires a dispensary to have a permit to operate.

A dispensary may only dispense medical cannabis to a patient or caregiver who presents a valid identification card, verified by a dispensary employee. The employee must enter a receipt containing specified information in the electronic tracking system and offer it to the patient or caregiver. After the receipt is given and information entered into electronic tracking system, the patient information must be removed from dispensary's computer system. Dispensing is limited to the practitioner's recommendation and no more than a 30-day supply may be dispensed to a patient at one time. A patient's supply may not be refilled until only a seven-day supply is left.

The rule sets forth requirements for dispensary facilities, allows a dispensary to offer items and services related to the use of medical cannabis with the written permission of the bureau, and prohibits advertising, marketing, and delivery.

The rule contains specific requirements for labels and safety inserts, plans of operation that must be submitted with the application, visitor access to dispensary facilities, security and surveillance, use of the electronic tracking system to maintain inventory data, storage, and facility sanitation and safety.

The sections of the rule relating to the transportation of the cannabis, the transport manifest, adverse loss during transport, and complaints about, or recall of, medical cannabis mirror those in the rule on growers/processors.

Finally, dispensaries are required to use the electronic tracking system prescribed by the bureau and the bureau may permit an additional location for the dispensary.

Department of Health and Human Resources, Medical Cannabis Program –Safe Harbor Letter, 64 CSR 113

The rule establishes the requirements for obtaining a safe harbor letter for a terminally ill cancer patient to use medical cannabis purchased in another state that has entered into a reciprocity agreement with the bureau. It sets forth application requirements which include a photo ID to prove identification and residence and a written statement from the patient’s physician.

A Safe Harbor Letter is valid until August 1, 2020, except under specified circumstances. The rule sets forth circumstances for when a new application would need to be submitted, provides for revocation of the safe harbor letter, and provides for information to be exempted from the state Freedom of Information Act.

In Pennsylvania, this was meant as a transition piece to implement legislation allowing sick kids to go out of state to obtain medical marijuana. Practically, marijuana is still a Schedule I controlled substance under federal law. It is also a federal offense to transport marijuana across state lines. Many states will not accept this letter to dispense medical marijuana.

Moreover, the forms of marijuana that have been legalized in West Virginia may not be the same as those that have been legalized in other states. West Virginia law authorizes the use of medical marijuana in the form of pills, oil, tincture, liquid, topical treatment, or a form medically appropriate for vaporization. It specifically excludes dry leaf or plant form. Because medical marijuana obtained outside of West Virginia must be legal under West Virginia’s Medical Cannabis Act, possession of the dry leaf or plant form would not be protected.

Therefore, even if approved, there will not be ready access to medical marijuana contemplated by this provision until the industry is established in West Virginia.

Department of Health and Human Resources, Collection and Exchange of Data Related to Overdoses, 69 CSR 14

The rule establishes the requirements to facilitate the exchange of overdose data and information among the Office of Drug Control Policy, Department of Health and Human Resources and its bureaus, the Department of Military Affairs and Public Safety, the Department of Administration, the administrator of the court, the Poison Control Center, the Board of Pharmacy, law enforcement, local health departments, and emergency medical services in each county.

The rule reduces the number of entities required to report overdose information and the number of data elements each mandatory report must contain. Information must be reported within 72 hours of the event, instead of quarterly. An information technology reporting platform is required, which eliminates email reporting. This information, once aggregated, is available to multiple entities.

Department of Health and Human Resources, Minimum Licensing Requirement for Residential Child Care, 78 CSR 03

The rule establishes standards and procedures for the licensure of residential childcare and treatment facilities under the provisions of W. Va. Code §49-2-101. This rule is updated to implement the Family First Prevention Services Act. It applies to congregate living facilities that serve children and transitioning

adults. These now include, but are not limited to, residential crisis support or emergency shelter care for vulnerable children; high quality group residential childcare settings for vulnerable children; and quality residential treatment programs.

The rule requires an organization to submit a request for a criminal history background check and a protective services records check to the WV Clearance for Access: Registry & Employment Screening (WV CARES) unit of the Department. The organization must also obtain a WV CARES self-disclosure application and consent form signed by the potential employee or contractor indicating any past criminal convictions or pending charges.

The rule allows a facility, following written approval by the Secretary, to use delayed-egress electrically locking systems. The facility must submit a written request that includes: the areas where the locking systems will be used; documentation from the State Fire Marshal that the locking systems comply with state building codes; and the reason the locking system is necessary to serve the children in the facility. The Secretary shall determine if the needs of the children require this level of restriction and he or she shall revoke approval at his or her discretion.

Under the rule, the supervision of each child is determined by normalcy and a reasonable and prudent parent standard and must be documented in the child's detailed treatment plan. The shelter is required to provide sex trafficking prevention programming. It must provide a nationally recognized behavioral health program for known victims of sex trafficking.

Section 78-3-19, relating to High-quality Group Residential Child Care Programs for Vulnerable Children is new. It requires:

- All employees to be trained on prudent parenting standards;
- One employee who is authorized to apply the reasonable and prudent parent standards to decisions involving participation of the child in appropriate activities to be present on-site at all times;
- The shelter to provide a nationally recognized behavioral health program for known victims of sex trafficking, including opportunities for normalizing experience;
- An employee to child ratio of one to six during waking hours and a minimum of two employees present at all times when more than one child is present in the living unit;
- Additional backup care employees to be available for emergency situations; and
- An employee to child ratio of one to twelve during sleeping hours and a minimum of one employee per residential unit to be awake at all times when children are present in the unit.

Sex trafficking prevention must be provided by the organization and must include:

- Education about sex trafficking;
- Education about a person's vulnerabilities to sex trafficking and how to protect oneself;
- Education about enhancement of support systems;
- Education about services for housing and homelessness prevention; and
- Education to prevent running away.

Section 78-3-20, relating to Qualified Residential Treatment Program, is new. It requires a qualified residential treatment facility to be appropriately accredited as required by federal standards.

The minimum employee to child ratio for the treatment program shall be one to four during waking hours and one to eight during sleeping hours. During all hours, there must be capability to increase employee ratio in response to acuity.

The organization must have registered or licensed nursing staff and other licensed clinical staff who are onsite according to their treatment model, and available 24 hours a day, seven days a week.

The organization shall ensure that the staff participate as a member of the family and permanency team and in multidisciplinary treatment team processes. They must also participate with the family and permanency team in the development of a 30-day assessment. Clinical staff must conduct any assessments indicated by the child's medical needs, psychiatric needs, or both, during development of the plans of care, including the ability to self-medicate with supervision.

The following treatment services shall be provided by the organization, in addition to those described in this rule:

- Individualized medically necessary services for the population served;
- Family engagement activities with the child's family during the treatment process; and
- At least six months of family-based after-care services after a child's discharge.

The family and permanency team are to begin planning for discharge during the development of the long and short-term goals.

At least 30 days prior to discharge, the family and permanency team shall meet to develop the plan for after-care services.

The rule contains program-specific rules for maternity and parenting facilities. New language has been added requiring that children be cared for and supervised at the following levels:

- A minimum employee ratio of one to six shall be maintained during waking hours when children are on the grounds with a minimum of two employees present per residential living unit at all times when more than one child is present in the living unit;
- Additional or back-up care employees shall be available for emergency situations or to meet special needs presented by the persons in care; and
- A minimum employee to child ratio of one to twelve is required during sleeping hours and a minimum of one employee per residential unit must be awake at all times when children are present in the unit.

Department of Health and Human Resources, Qualifications for a Provisional License to Practice License to Practice as a Social Worker, 78 CSR 24

The amendments clarify who may participate in the Department of Health and Human Resources social work license training program by including individuals with a bachelor's degree not related to social work. They also allow individuals who are actively in the process of completing a degree in social work to apply completed social work courses toward the requirements of the Training Plan.

Department of Health and Human Resources, Pilot Program for Drug Screening of Applicants for Cash Assistance, 78 CSR 26

The authorizing statute for this rule was enacted in 2016. The Department had to get approval from the federal Administration for Children and Families. The rule was delayed one year and became operational in October of 2018. The pilot project was authorized for three years, so there is a need to extend the sunset date in the rule to 2021.

Health Care Authority, Critical Access Hospitals, 65 CSR 09

This new rule, required by Senate Bill 593 which passed during the 2019 Regular Session, establishes specific standards and procedures to provide for the designation of a critical access hospital as a community outpatient medical center.

It defines terms and sets forth eligibility requirements for a critical access hospital to apply for a designation change to become a community outpatient medical center. This includes licensure requirements, hours of operation, treatment options, required attempts to secure all written agreements with hospitals for patient referral, and operational policies from physicians.

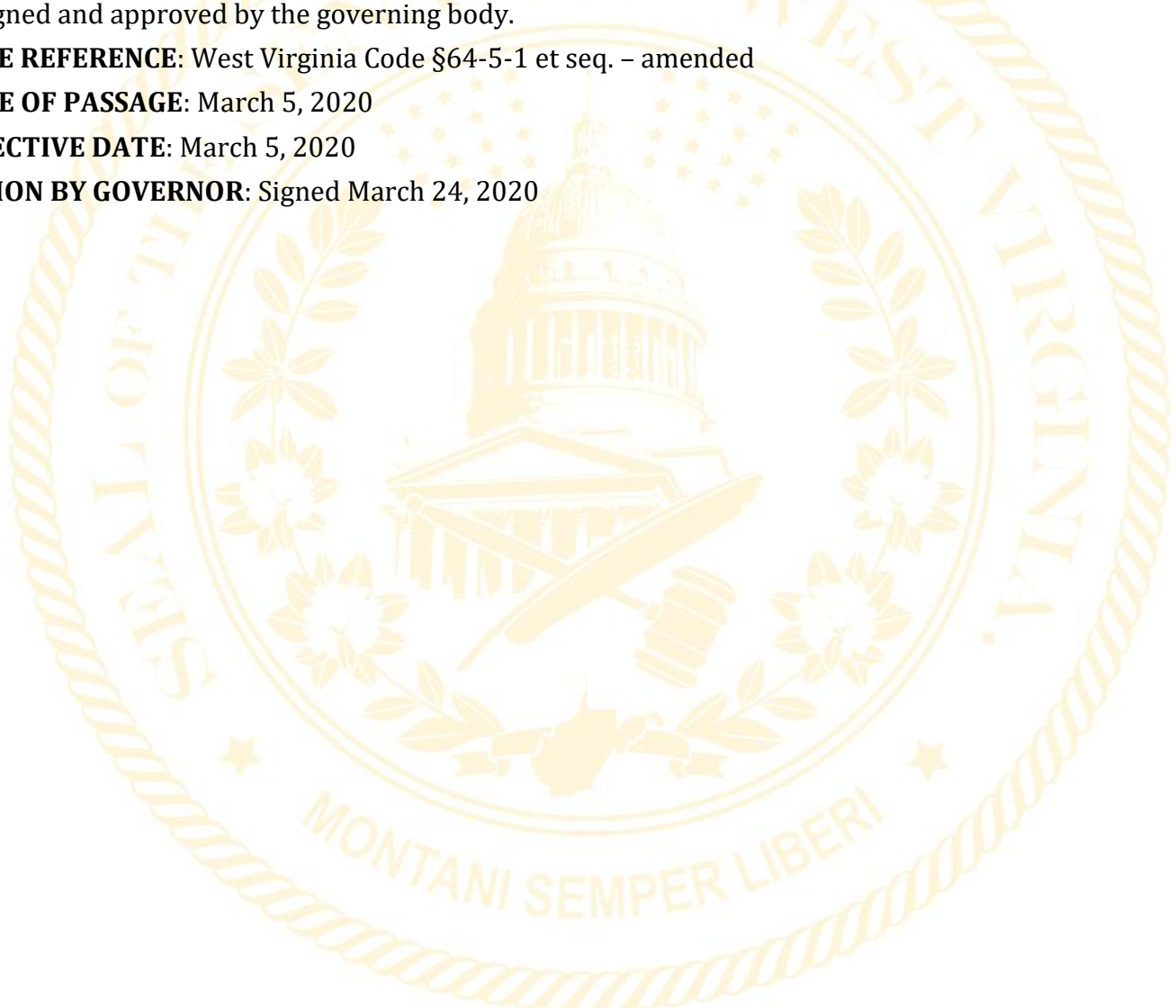
This rule also requires the community outpatient medical center to comply with Hospital Licensure Rule 64 CSR 12. The center's organization, scope of services, and availability of treatment services will be designed and approved by the governing body.

CODE REFERENCE: West Virginia Code §64-5-1 et seq. – amended

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: March 5, 2020

ACTION BY GOVERNOR: Signed March 24, 2020



Senate Bill 357

Authorizing Department of Revenue promulgate legislative rules

This bill is known as the Department of Revenue Rules bundle, which authorizes and directs the promulgation of seven rules, constituting Bundle 7. Only the legislative rules directly relating to the health care industry are included in this summary.

Insurance Commissioner, Medicare Supplement Insurance, 114 CSR 24

This is an amendment to an existing rule. The purpose of the rule is to provide standardized coverage and benefits of Medicare Supplement policies. The changes to the rule are necessitated by two factors: the enactment of the Medicare Access and CHIP Reauthorization Act of 2015; and changes made to the National Association of Insurance Commissioners (NAIC) model language.

Changes made in the federal law effect deductibles applicable to Plan B for any newly eligible person. This would be effective January 1, 2020. The current deductible is \$100, and federal law increased this to \$185. Additionally, there was the elimination of first dollar coverage – which means covering the Medicare Plan B deductible - for Medicare supplement policies. This resulted in the discontinued sale of Plans C and F. Persons who currently have a Plan C or F policy will remain eligible. Persons who become eligible after January 1, 2020 will not be permitted to purchase these plans. These changes are implemented in the proposed rule to ensure the state’s regulatory authority over all Medicare Supplement insurance products sold in West Virginia.

This bill also adds language to indicate that specified standard benefit plans issued following January 1, 2020 may be offered to persons eligible prior to that date. This relates primarily to Plan G, which is a high deductible plan. It prohibits states that had alternative simplification programs in place that had been approved by the federal government from covering the Part B deductible for any supplement policy sold or issued after January 1, 2020.

New language has been added that prohibits a rate structure for policies based upon groupings of attained ages greater than one year. These are known as “age bands,” which are defined as the range of ages that determines the premium amount for each policyholder or individual. Rates are required to increase “smoothly” from year to year.

There is a grandfathering provision that allows those plans which currently provide for multiple-year age banding at the time the rule becomes effective to transition to one-year age bands over a five-year period. There is also a provision that provides that an insurer may apply a maximum rate based upon reaching a certain age.

Insurance Commissioner, Credit for Reinsurance, 114 CSR 40

This is an amendment to an existing rule. The purpose for the changes is twofold. First, during the 2018 Regular Session, House Bill 4230 passed, which amended W. Va. Code §33-4-15a effective January 1, 2019. Secondly, on July 21, 2010 Congress passed the Non-admitted and Reinsurance Reform Act which had an impact on the National Association of Insurance Commissioner (NAIC) accreditation standards. This Act was intended to update and modernize reinsurance regulations throughout the country.

The proposed changes to the language in the rule come from model language of the NAIC and are necessary for NAIC accreditation. This situates West Virginia similarly with other states and allows the financial exams from West Virginia to be accepted by other states.

The purpose of the rule is to regulate reinsurance. This is a complicated concept described by the NAIC as insurance of insurance companies. It is an indemnity between a reinsurer and an insurer. It operates as a transfer of risk from an insurer to the reinsurance company, which contractually assumes all or part of the risk of one or more insurance policies issued by the insurance company. This is an essential part of the insurance industry to manage risks.

A great many of the changes to this rule pertain to updating code referencing based upon changes made in House Bill 4230 in 2018. Additionally, terms are updated to reflect current practice and changes made by the NAIC.

Insurance Commissioner, Pharmacy Auditing Entities and Pharmacy Benefit Managers, 114 CSR 99

The purpose of this rule is to implement the Pharmacy Audit Integrity Act and to provide licensing, reporting, and activity standards for pharmacy benefit managers which provide claims processing services or other prescription drug or device services, or both, for health benefit plans. This rule was filed pursuant to Senate Bill 489, which was adopted during the 2019 Regular Session.

This rule provides for the registration of auditing entities, the licensure and renewal licensure of pharmacy benefit managers, and the denial of applications; sets forth prohibited acts; requires a pharmacy benefit manager to maintain an adequate network for the provision of prescription drugs for a health benefit plan; provides for the Commissioner to examine the affairs of a pharmacy benefit manager for compliance; and authorizes the Commissioner to suspend or revoke a license and order the pharmacy benefit manager to pay a penalty fee for violation of the statute or rule.

State Tax Division, Consumer Sales and Service Tax and Use Tax – Drugs, Durable Medical Goods, Mobility Enhancing Equipment and Prosthetic Devices Per Se Exemption; Motor Vehicles Per Se Exemption, 110 CSR 15C

This is an amendment to an existing rule. It incorporates the changes made to W. Va. Code §11-15-9i during the 2019 Regular Session with the passage of House Bill 2515.

The provisions of this bill provide for an exemption from sales and use tax for the sale and installation of mobility enhancing equipment in a new or used motor vehicle for the use of a person with physical disabilities. The exemption extends to the sale and installation of repair or replacement parts.

CODE REFERENCE: West Virginia Code §64-7-1 et seq. – amended

DATE OF PASSAGE: February 5, 2020

EFFECTIVE DATE: February 5, 2020

ACTION BY GOVERNOR: Signed February 14, 2020

Senate Bill 544

Authorizing pharmacists and pharmacy interns administer vaccines

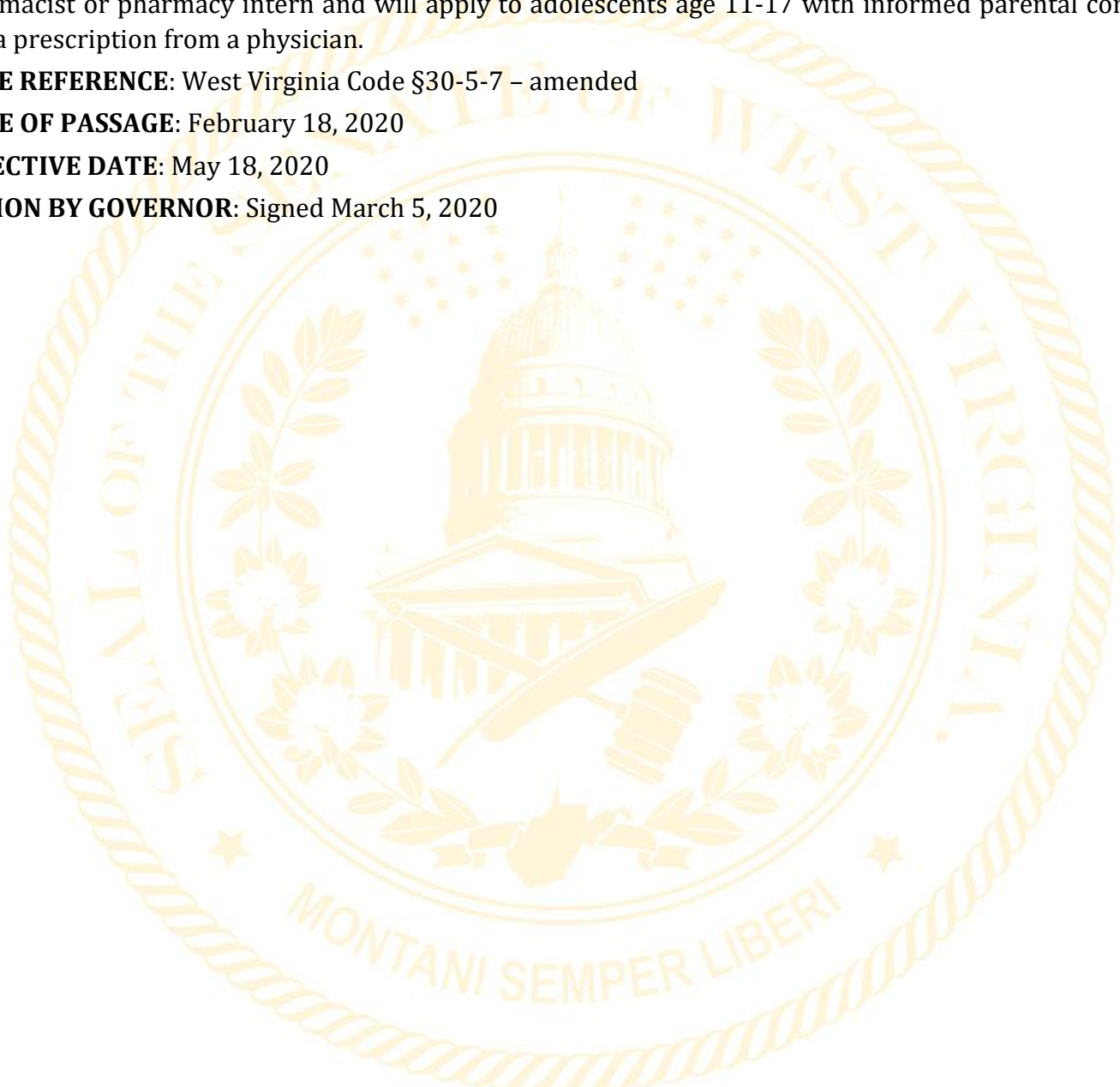
The bill permits the Board of Pharmacy, the Board of Medicine and the Board of Osteopathic Medicine to propose joint rules for legislative approval to permit a licensed pharmacist or pharmacy intern to administer immunizations in accordance with definitive treatment guidelines for immunizations issued by the Centers for Disease Control for adults, children and adolescents. The joint rules shall permit a licensed pharmacist or pharmacy intern and will apply to adolescents age 11-17 with informed parental consent and a prescription from a physician.

CODE REFERENCE: West Virginia Code §30-5-7 – amended

DATE OF PASSAGE: February 18, 2020

EFFECTIVE DATE: May 18, 2020

ACTION BY GOVERNOR: Signed March 5, 2020



Senate Bill 560

Permitting nursing home use trained individuals administer medication

The bill requires the Office of Health Facility Licensure and Certification (OHFLAC) to create a program for the administration of medication in nursing homes. The administration of the medication shall be performed by an approved medication assistive personnel (AMAP) who has been trained and retrained every two years, and passed a national medication aide certification examination and who is subject to the supervision and approval of a registered nurse.

The AMAP must meet the eligibility requirements, have successfully completed a nationally recognized model curriculum for certified assistants, has passed a national medication aide certification examination approved by the National Council of State Boards of Nursing and is considered competent by the authorized registered professional nurse to administer medications to residents.

The bill provides that the AMAP is exempt from chapter 30 licensure requirements and provides that a health care professional remains subject to this or her respective licensing laws. The bill further provides that the bill shall not be construed to violate or conflict with chapter 30.

The bill requires that OHFLAC's training curricula be based on a nationally recognized model. OHFLAC shall consult with the WV Board of Respiratory Care in training curricula regarding the use of an inhaler or nebulizer. The bill requires an AMAP to have a high school diploma, be a nurse aide with at least one year of full time experience, be certified in cardiopulmonary resuscitation and first aid; participate in the initial training program developed by OHFLAC; pass a national certification examination developed by OHFLAC; not have a statement on the stated administered nurse aide registry indicating that the staff member has been the subject of finding of abuse and neglect of a long-term care nursing home resident or convicted or the misappropriation of a resident's property; and participate in a retraining program every two years. The bill provides that a registered professional nurse shall offer training to its staff members.

In order to administer medication, the AMAP shall: determine the medication is in its original container in which it was dispensed by the pharmacist or physician; make a written record of assistance or medication with regard to each medication administered, including time, route and amount taken; display the title "Approved Medication Assistive Personnel" and comply with the legislative rules promulgated to implement this provision and that the rule address at a minimum the supervision provided by the registered nurse to the AMAP.

The bill requires that the nursing homes establish administrative monitoring and shall comply with the existing AMAP rule.

The bill permits a nurse who supervises an AMAP to withdraw authorization for an AMAP to administer medications if the nurse determines that the AMAP is not performing the function in accordance with the training and written instructions. This shall be documented and relayed to the nursing home and OHFLAC. OHFLAC shall maintain a list of names of person whose authorization has been withdrawn and this list may be accessed by nurses and personnel of nursing homes.

The bill permits the collection of fees by OHFLAC.

The bill provides for limitations on medication administration. An AMAP may not administer the first dose of medication, perform an injection, administer irrigations or debriding agents, act upon verbal orders, transcribe medication orders, convert or calculate drug dosages, administer medication as needed, perform health maintenance checks, the AMAP may not be assigned medication administration duties and typical nurse aide duties.

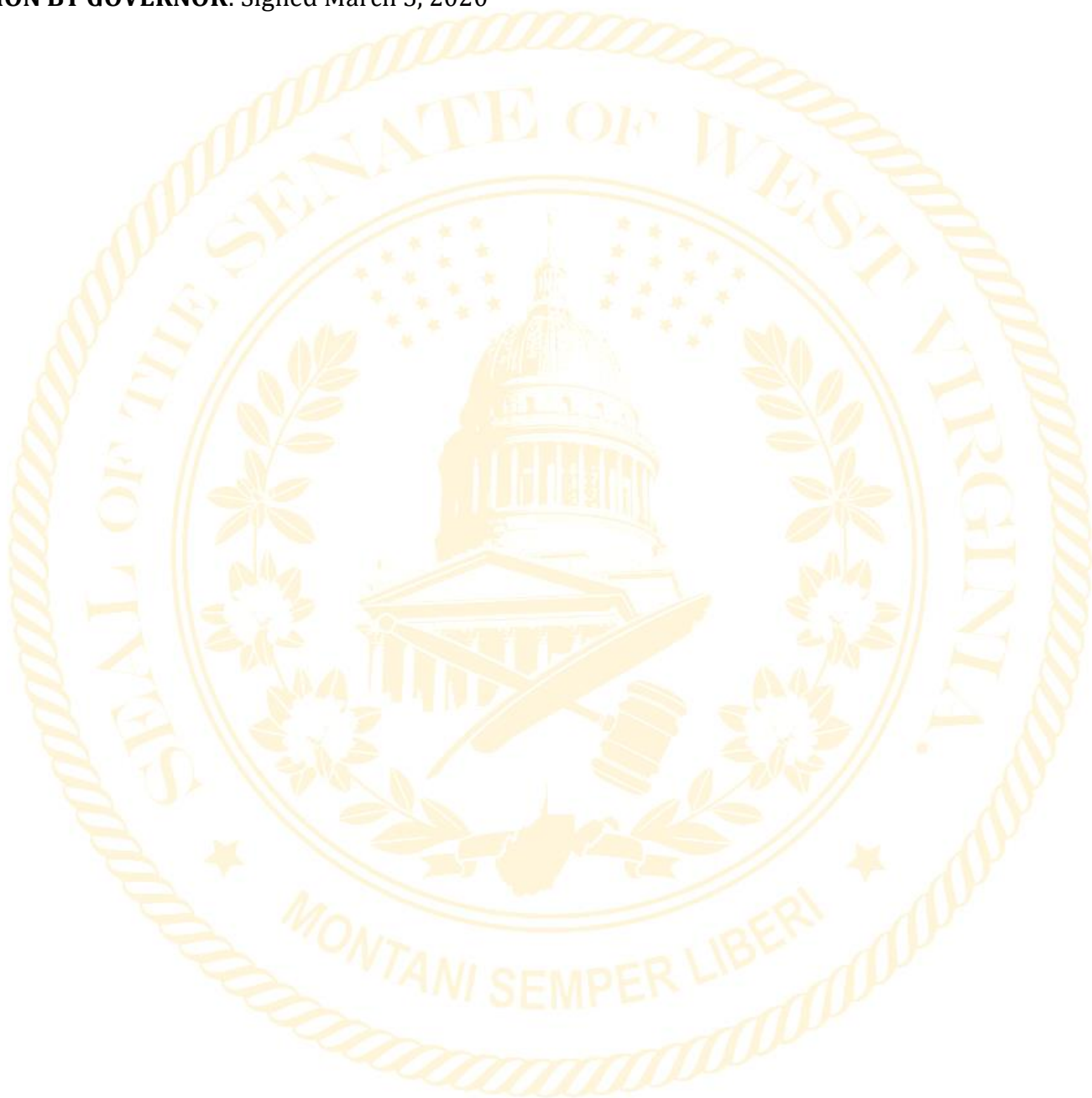
The bill provides that the provisions are not mandatory upon any nursing home or employee.

CODE REFERENCE: West Virginia Code §30-7D-1 through §30-7D-13 – repealed; §16-5AA-1 through §16-5AA-10 – new

DATE OF PASSAGE: February 18, 2020

EFFECTIVE DATE: May 18, 2020

ACTION BY GOVERNOR: Signed March 5, 2020



Senate Bill 575

Designating local fire department as safe-surrender site to accept physical custody of certain children from lawful custodian

The bill adds the fire department that has been designated as a safe surrender site as an additional location for a child to be voluntarily relinquished within 30 days of birth. The bill provides procedures after the fire department takes possession of the child, including delivery to the nearest hospital including that transport shall begin no later than 30 minutes upon taking possession of a child; notification of child protective services within two hours of taking possession of a child; and handling of further inquiries. The bill details the process for designation of the fire department as a safe surrender site, including that the fire department must be staffed 24 hours a day seven days a week.

CODE REFERENCE: West Virginia Code §49-4-201 and §49-4-202 – amended; §49-4-206 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 641

Allowing WVCHIP flexibility in rate setting

The bill removes a requirement that the Children’s Health Insurance Program use provider schedules that are no lower than those schedules provides for in W.Va. Code §5-16-1 et seq. of the code relating to the Public Employees Insurance Agency.

CODE REFERENCE: West Virginia Code §5-16B-6d – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 647

Permitting physician's assistants and advanced practice registered nurses issue do-not-resuscitate orders

The bill expands the medical professionals that can issue a do-not-resuscitate order. Currently, the order can only be issued by a physician. This bill allows the order to be written by a physician assistant or advanced practice registered nurse.

CODE REFERENCE: West Virginia Code §16-30C-6 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 648

Providing dental coverage for adult Medicaid recipients

The bill requires dental coverage for adult Medicaid recipients. Adults are defined as age 21 and over covered by Medicaid. The dental program shall provide coverage for diagnostic services, preventative dental services and restorative services. Coverage of cosmetic services are excluded. Diagnostic and preventative services include dental work that maintains good oral hygiene, which includes oral evaluations, routine cleanings, x-rays, fluoride treatment, fillings and extractions. Restorative services pertain to dental work involving tooth replacement, including, but not limited to dentures, dental implants, bridges, crowns, or corrective procedures such as root canals. Coverage is limited to \$1000.00 per budget year. Any costs over \$1000.00 per budget year shall be paid by the recipient.

The bill provides that the Department of Health and Human Resources (DHHR) is responsible for implementation of the program, including the program design for the dental health system. The dental health system design shall include oversight, quality assurance measures, case management and patient outreach activities. The DHHR shall also assume responsibility for claims processing in accordance with established fee schedules and financial aspects of the program necessary to receive available federal dollars to meet federal rules and regulations.

The provisions of this section shall only become effective upon approval from the federal Centers for Medicare and Medicaid Services of the provider tax set forth in W.Va. Code §11-27-10a of this code.

CODE REFERENCE: West Virginia Code §9-5-12a – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020 (and also upon approval of the federal Centers for Medicare and Medicaid Services of the Provider Tax set forth in West Virginia Code §11-27-10a)

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 664

Adding physician's assistant to list of medical professionals capable of determining if individual lacks capacity

The bill adds a physician assistant to the list of medical professionals who can determine if an individual lacks capacity. The bill also updates terminology related to the advanced practice registered nurse. The previous terminology was advanced nurse practitioner. Further, the bill permits the treating physician, psychologist, physician assistant, or an advanced practice registered nurse, who has personally examined the person, to inform that person, if conscious, that the individual has been determined to be incapacitated and that a medical power of attorney or surrogate decision maker may be making decisions regarding life-prolonging intervention or mental health treatment for that person.

The determination of incapacity shall be recorded contemporaneously in the person's medical record by the attending physician, a physician, a physician's assistant, an advanced practice registered nurse or a qualified psychologist.

CODE REFERENCE: West Virginia Code §16-30-7 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 4, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 689

Enacting Requiring Accountable Pharmaceutical Transparency, Oversight, and Reporting Act

The proposed bill requires that drug manufacturers and health benefits plans who prescribe prescription drugs or provide prescription drugs coverage in WV to provide cost information, changes in cost information, and prescription drug statistics to the State Auditor. The bill requires the Auditor to publish this information on a searchable transparency website available to the public and disclose identities of drug manufacturers and health benefits plans issuers who fail to comply with the requirements of the article. The bill requires the Auditor's searchable pharmaceutical transparency website to be created and available to the public at no cost by July 1, 2021.

The bill clarifies the definition of health benefit plan issuer, which for purposes of this article, does not include insurers or managed care organization with respect to their Medicaid or CHIP plans or contracts which are reviewed and approved by the Department of Health and Human Resources Bureau of Medical Services.

The bill also implements a reporting requirement upon the Auditor to compile a report detailing information obtained and submit the analysis to LOCHHRA.

CODE REFERENCE: West Virginia Code §33-53-1 through §33-53-5 – new

DATE OF PASSAGE: March 6, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 707

Relating to nursing career pathways

This bill creates a nursing career pathway. It sets forth legislative findings regarding a statewide nursing shortage and the need to provide a seamless pathway for students pursuing careers in nursing beginning in high school through attainment of a nursing credential or degree. The bill requires the State Superintendent, Higher Education Policy Commission Chancellor and the Community and Technical College Council Chancellor to establish a West Virginia Nursing Career Pathway Workgroup consisting of representatives of:

- Health care providers that need nurses and could potentially provide clinical space; Department of Education; Higher Education Policy Commission; Community and Technical College Council; Institutions of higher education; Board of Registered Professional Nurses; Board of Examiners for Licensed Practical Nurses; and other persons determined beneficial by the Superintendent and Chancellors.

This work group is charged with developing a career pathway to address the unmet need for nursing assistants, licensed practical nurses, registered nurses, and registered nurses with a bachelor's degree in nursing. The pathway will begin in high school and progress through college, providing employment opportunities with industry partners and pathway re-entry at specified attainment points:

- Nursing assistant certification;
- Licensed practical nurse diploma and licensure;
- Registered nurse associate degree and licensure; and
- Bachelor of science in nursing completion.

The career pathway shall align affordable, effective and sustainable secondary to post-secondary nursing programs to increase credential attainment for a broad and diverse student population.

The bill sets forth a career pathway that shall be made available beginning with the cohort of students entering ninth grade during the 2021-2022 school year. The pathway shall include participating high school students enrolled in specified college preparatory courses, career and technical health science courses, dual-college-high school credit courses, or participating career experiences. The pathway requires that the student have the opportunity to apply for admission to the next step in the pathway.

The Superintendent, Chancellors, or any combination thereof, shall report to the Legislative Oversight Commission on Education Accountability (LOCEA) on the progress in implementing the career pathway up until this pathway has been fully implemented statewide.

The bill also provides that, in the event that difficulties arise during the implementation process, the work group shall consider online programs to be used to increase statewide accessibility of nursing programs, and that the pathway includes the use of any available financial assistance in order to significantly reduce, or if possible, eliminate, tuition costs of this program for students and their families. Finally, the bill lists financial aid that may be included and encourages health care providers to establish scholarship programs.

CODE REFERENCE: West Virginia Code §18-2E-11a – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: March 7, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 716

Requiring DHHR pay for tubal ligation without 30-day wait between consent and sterilization

The bill requires the Department of Health and Human Resources to pay for tubal ligation without requiring a thirty-day waiting period between informed consent and the tubal ligation procedure.

CODE REFERENCE: West Virginia Code §9-5-12 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: July 1, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

Senate Bill 719

Imposing health care-related provider tax on certain health care organizations

The bill updates the tax amounts in Tier I, Tier II, and Tier III to permit additional federal match. The tax will only take effect upon approval of the federal Centers for Medicare and Medicaid Services. This approval has not yet been received and no tax has been implemented. The end date of the tax was extended until June 30, 2023.

CODE REFERENCE: West Virginia Code §11-27-10a – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: July 1, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 746

Providing contracted managed care companies access to uniform maternal screening tool

The bill permits managed care organizations with respect to Medicaid or CHIP plans or contracts which are reviewed and approved by the DHHR and DHHR Bureau for Medical Services to be provided data from the uniform maternal screening tool regarding their own covered members. The bill provides that the contracted managed care companies and Bureau for Medical Services must maintain the confidentiality of the data received.

CODE REFERENCE: West Virginia Code §16-4E-6 – amended

DATE OF PASSAGE: March 6, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 747

Requiring Bureau for Public Health develop Diabetes Action Plan

The bill requires the Bureau of Public Health to create a Diabetes Action Plan. This plan includes convening a diabetes task force consisting of stakeholders to develop the plan. They will conduct data and infrastructure/gap analyses. The task force will draft a plan to include a long-and-short-term goals diabetes prevention and management which will be published for public comment. A briefing document will be produced promoting use of strategies outlined in the plan to distribute to stakeholders. The task force will implement plans to decrease the prevalence of diabetes and track and trend relevant statistics regarding diabetes. The plan shall be completed and presented to LOCHHRA by January 1, 2021.

CODE REFERENCE: West Virginia Code §16-1-20 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 748

Increasing awareness of palliative care services

The purpose of this bill is to increase awareness of palliative care by requiring the State Advisory Coalition on Palliative Care, in conjunction with the Bureau of Public Health to develop educational material on the topic. These materials will, at a minimum, provide an overview of palliative care services and a description of the interdisciplinary team for distribution to the public. The bill also provides definitions for “palliative care” and “interdisciplinary teams”.

CODE REFERENCE: West Virginia Code §16-60-1 through §16-60-3 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 749

Requiring Fatality and Mortality Review Team share data with CDC

The bill permits the Bureau for Public Health to submit its maternal mortality data to the Centers for Disease Control and Prevention for data aggregation. It permits a peer review report to be made to birth hospitals and requires Infant and Mortality Review Panel to annually analyze factors impacting maternal and infant mortality and prepare a report. It further requires the Bureau for Public Health to perform multi-year analysis to recommend system change to reduce maternal and infant deaths.

CODE REFERENCE: West Virginia Code §61-12A-2 and §61-12A-4 – amended; §61-12-A-5 – new

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 767

Relating to licensure of hospitals

The bill requires the Department of Health and Human resources grant an exemption from a periodic license inspection during the year following accreditation if the hospital submits evidence by enumerated accredited organizations, including any accrediting organization approved by the Centers for Medicare and Medicaid Services, along with the accrediting report.

The second portion of the bill repeals the requirement related to hospital board composition.

CODE REFERENCE: West Virginia Code §16-5B-5a – amended; §16-5B-6a – repealed

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 770

Revising requirements for post-doctoral training

The bill revises the requirements for post-doctoral training as a requirement for licensure as an osteopathic physician. The bill removes an alternative requirement that a minimum of one year post-doctoral an applicant complete 40 hours of continuing medical education in osteopathic manipulative medicine. The removal of this requirement will create parity with MDs. The proposed bill provides definitions. Additionally, the bill makes technical changes and removes the requirements for moral character.

CODE REFERENCE: West Virginia Code §30-14-2 and §30-14-4 – amended

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 787

Providing benefits to pharmacists for rendered care

The bill provides that for health plans issued or renewed after January 1, 2021 benefits may not be denied for any health care service performed by a licensed pharmacist. The proposed bill provides that the benefits may not be denied for any health care service performed by a pharmacist if the service is performed within the lawful scope of the pharmacist scope of work, the plan would have provided benefits if the service had been performed by another health care provider, and the pharmacist is in the network.

The proposed bill provides that for plans that renew on or after January 1, 2020 but before January 1, 2021, credentialing shall start. Additionally, health plans shall reimburse facilities for covered services provided by network pharmacies within the pharmacist's scope of practice per negotiations with the facility. The bill excludes Medicaid or CHIP or agreements are approved by the DHHR.

CODE REFERENCE: West Virginia Code §33-53-1 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 797

Authorizing governing boards of public and private hospitals employ hospital police officers

The bill permits the governing board of a hospital to establish a hospital police department. The bill sets the qualifications of the hospital police department and the powers and duties and the hospital police officer. The bill permits hospital police officers to assist local law enforcement agencies. The bill inserts a clause related to de-escalation training of the hospital police force.

CODE REFERENCE: West Virginia Code §17-1-6, §30-29-1, §30-29-5, and §30-29-8 – amended; §16-5B-19 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 830

Eliminating special merit-based employment system for health care professionals

The bill is to repeal a section of the code created last session to permit the Department of Health and Human Resources to develop a special merit-based system including specific classifications for state operated acute care, long-term care, psychiatric care facilities. The implementation time frame was January 1, 2020 to July 1, 2020.

CODE REFERENCE: West Virginia Code §5-5-4a – repealed

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: June 3, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

Senate Bill 846

Requiring hospital publish notification prior to facility closure regarding patient medical records

The bill requires a hospital, extended care facility operated in conjunction with a hospital, ambulatory care facility or ambulatory surgical facility operated in connection with a hospital that intends to terminate operations to publish a Class III legal advertisement (once a week for three weeks) three weeks prior to the projected closure date informing the public where medical records, including imaging studies and films, may be obtained. The notice shall contain contact information. Upon closure, a second Class III legal advertisement must be published with the same notification requirements. The bill also requires publication on the facility web page. The confidentiality of the medical records shall be maintained during storage.

The bill requires a response within 30 days or subject to a fine of \$25 per day to be assessed by a court with jurisdiction.

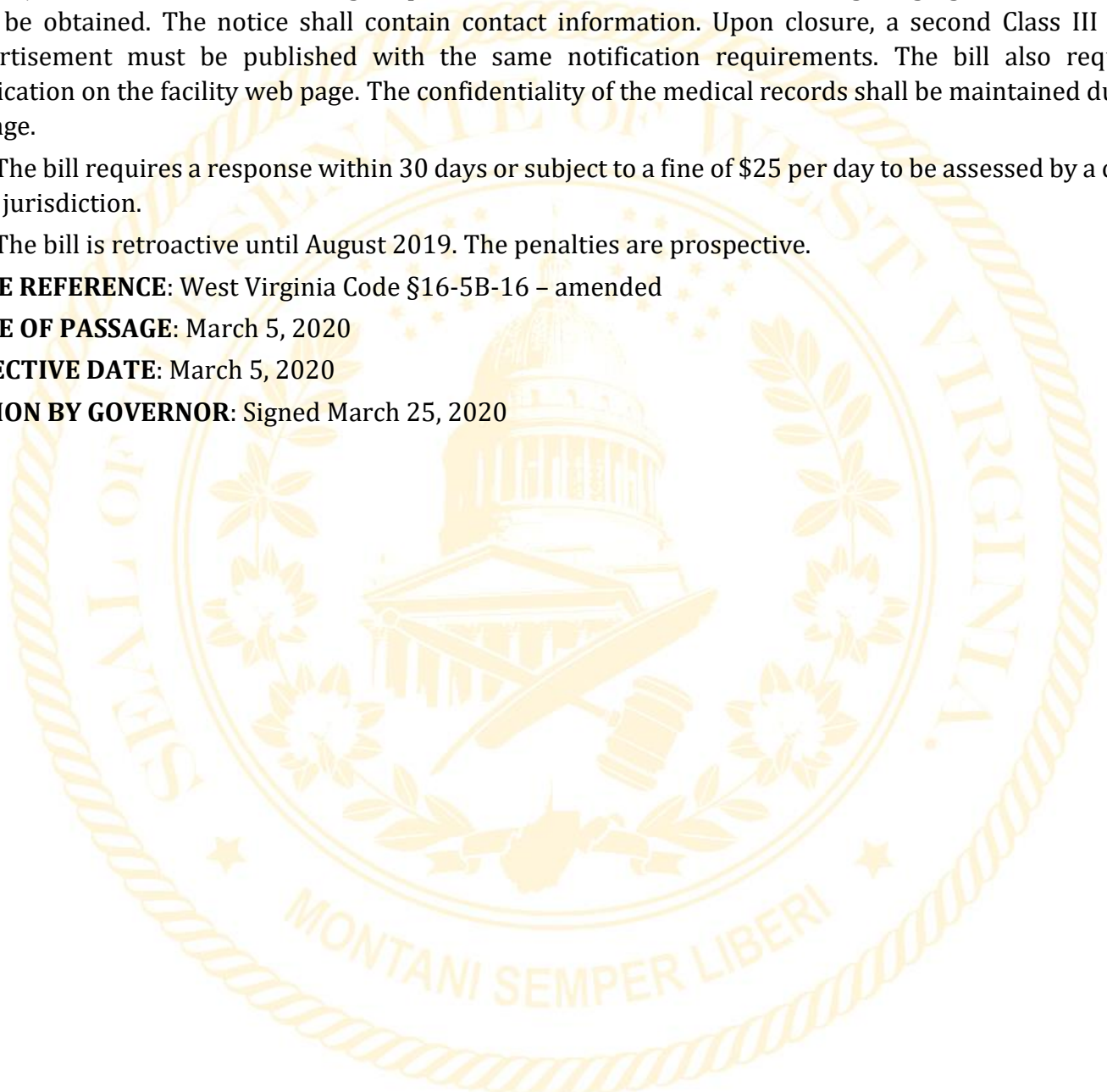
The bill is retroactive until August 2019. The penalties are prospective.

CODE REFERENCE: West Virginia Code §16-5B-16 – amended

DATE OF PASSAGE: March 5, 2020

EFFECTIVE DATE: March 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



House Bill 4003

Relating to telehealth insurance requirements

The purpose of this bill is to establish statutory parameters concerning telehealth by defining terms and establishing minimum health care insurance requirements. Chapter 30 boards are required to promulgate a legislative rule to regulate telehealth practice for each applicable profession.

The bill sets forth the minimum insurance requirements for coverage for telehealth services, excluding audio-only services. All insurers providing health care insurance shall:

- Provide coverage of health care services provided through telehealth services if those same services are covered through face-to-face consultation by the insurance policy;
- Not exclude a service for coverage solely because the service is provided through telehealth services;
- Provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company; and,
- Not impose any additional dollar maximum amounts, deductible amounts, or limitations that are not equally imposed on all terms and services covered by the policy, contract, or plan.

CODE REFERENCE: West Virginia Code §5-16-7b, §30-1-25, and §33-53-3 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4007

Born-Alive Abortion Survivors Protection Act

This bill creates the Born-Alive Abortion Survivors Protection Act. The bill requires medical personnel performing an abortion to provide an aborted fetus the same degree of medical assistance that a non-aborted fetus would receive at the same gestational point if the fetus meets the definition of “born alive,” including transporting the born alive fetus to a hospital. The bill makes the failure to provide the required care a violation of the standard of care for licensed medical practitioners. The bill also provides that any person, not a physician or licensed medical professional, who violates the new requirements is guilty of unauthorized practice of medicine, a felony punishable by one to five years of incarceration, a fine of up to \$10,000, or both incarceration and the fine. The bill adopts definitions from the Pain Capable Unborn Child Protection Act.

CODE REFERENCE: West Virginia Code §16-2P-1 – new

DATE OF PASSAGE: February 19, 2020

EFFECTIVE DATE: May 19, 2020

ACTION BY GOVERNOR: Signed March 2, 2020

House Bill 4009

Relating to the process for involuntary hospitalization

This bill updates provisions of the mental hygiene law by: 1) requiring training in mental health law for all magistrates; 2) making all magistrates available to hold certain mental health hearings; 3) replacing the term “addiction” with “substance use disorder;” and 4) requiring inquiry of hospitals prior to transporting patients.

Section 27-6A-12, which is new, requires the Secretary of the Department of Health and Human Resources to collaborate with the West Virginia Supreme Court of Appeals, prosecutors, providers, and advocates to propose legislation to deal with shortcomings in current law and to provide the legislation to the President and Speaker by July 31, 2020.

This bill also creates a process for involuntary hospitalization when: 1) a person is present at, or presented, at a hospital; 2) if a mental hygiene commissioner, a county magistrate, or a circuit court judge are unavailable or are unable to be contacted; and 3) if the staff physician believes that the individual is addicted or is mentally ill and because of his or her mental illness is likely to cause serious harm to himself, herself, or others if allowed to remain at liberty.

The bill provides that immediately or as soon as practicable thereafter, but in no event later than 24 hours after the involuntary hospitalization, the authorized staff physician or designated staff shall file a mental hygiene petition in which the staff member certifies the individual is likely to cause serious harm to himself, herself, or others if allowed to remain at liberty.

The bill provides that an individual who is involuntarily hospitalized must be released within 72 hours, unless further detention proceedings occur.

Under this bill, treatment may be rendered to the individual upon consent of the individual or in the event of a medical or psychiatric emergency. Additionally, the medical provider must exercise due diligence in determining the individual’s existing medical needs and provide treatment the individual requires, including previously prescribed medication.

The bill provides for payment of the provider at the negotiated rate and if the individual is uninsured, allows a claim to be filed with the Legislative Claims Commission.

The bill provides for immunity from liability if all actions are performed in conformity with the standard of care.

The bill requests that the West Virginia Supreme Court of Appeals provide each hospital with a list of names and contact information for the mental hygiene commissioners. It also provides that if a mental hygiene commissioner, county magistrate, or circuit judge does not respond to the request within 24 hours, a report shall be filed with the West Virginia Supreme Court of Appeals.

CODE REFERENCE: West Virginia Code §27-1-11, §27-5-1, §27-5-2, §27-5-3, §27-5-4, and 27-5-10 – amended; §27-5-2a and §27-6A-12 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4058

Relating to pharmacy benefit managers

This bill makes technical changes correcting various internal citation errors. This bill re-inserts language that was previously deleted in this section providing for penalties.

Based upon this change, rules adopted pursuant to this bill, shall set forth penalties or fines, including without limitation fines, suspension of licensure, and revocation of licensure for violations. The bill specifies that a person who violates this provision or the legislative rules implementing its provisions may be fined not less than \$1,000 nor more than \$10,000 per violation.

CODE REFERENCE: West Virginia Code §33-51-8 and §33-51-10 – amended

DATE OF PASSAGE: February 29, 2020

EFFECTIVE DATE: May 18, 2020

ACTION BY GOVERNOR: Signed February 29, 2020



House Bill 4061

Health Benefit Plan Network Access and Adequacy Act

This bill creates the Health Benefit Plan Network Access and Adequacy Act. It requires a health carrier providing a network plan to maintain a network that is sufficient in numbers and appropriate types of providers, including those that service predominately low-income, medically underserved individuals. It requires that covered persons have 24/7 access to emergency services. It is applicable to accident and sickness insurance, group accident and sickness insurance, hospital service corporations, medical service corporations, dental service corporations, health service corporations, health care corporations, and health maintenance organizations. It is not applicable to limited scope dental plans or limited scope vision plans.

Beginning January 1, 2021, a health carrier is required to file a newly offered network and access plan with the Commissioner for review. This access plan may be considered proprietary information. The bill specifies the contents of the access plan.

The bill requires a health carrier to post a current provider directory for each of its network plans electronically and to update the directory on a monthly basis. The directory is to describe in plain language how it tiers providers and note that authorization is required to access some providers. It must provide certain specified information and be accessible to persons with disabilities.

For insurers and lines of insurance that provide dental care coverage, this bill provides that if an insured provides dental care coverage to a covered person, it must honor an assignment of payment, made in writing by the covered person, of payments due under the policy to a dentist or a dental corporation for services provided to the covered person that are covered under the insurance policy. Upon notice of the assignment, the insurer must make payments directly to the provider of the covered services. In other words, the bill would entitle an out-of-network provider to receive benefits directly from an insurer if the insurer's covered person has provided a written assignment of benefits to the out-of-network provider.

The bill provides that a provider with a valid assignment may bill the insurer and notify the insurer of the assignment. Upon request of the insurer, the provider would have to provide a copy of the assignment to the insurer. The bill also provides that if, under an assignment, a provider collects payment from a covered person and subsequently receives payment from the insurer, the provider must reimburse the covered person, less any applicable copayments, deductibles, or coinsurance amounts, within 45 days.

CODE REFERENCE: West Virginia Code §33-15-4u, §33-15-22, §33-16-3ff, §33-16-18, §33-24-7u, §33-24-45, §33-25-8r, §33-25-22, §33-25A-8u, §33-25A-36, and §33-53-1 through §33-53-13 - new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4092

Relating to foster care

This bill sets forth a number of objectives to improve the foster and kinship care system in this state. The bill revises definitions and creates new ones. The bill repeals outdated requirements for staffing complement and education of the public. It updates language for several provisions of existing code.

With respect to the performance-based contracting with child placing agencies, the bill provides a \$1,000 payment to child placing agencies for each completed adoption. The rate of payment to foster parents and child placing agencies must be evaluated every three years.

The bill establishes funding priorities that, subject to appropriations of the Legislature, authorize and directs the department to: 1) Enhance and increase efforts to provide services to prevent removal; 2) Identify relatives and fictive kin of a child in need of placement outside of his or her home; 3) Train persons providing kinship placements to become certified foster parents; 4) Expand a tiered foster care system no later than December 1, 2020; and 5) Develop a pilot program to increase payment to uncertified kinship placements for the purpose of further helping families who have accepted kinship placements. During fiscal year 2021, the department must expend at least \$16,900,000 for the purposes of implementing this section.

The bill states that Certificate of Need requirements do not apply.

The bill sets forth a Foster Child Bill of Rights and a Foster Parent and Kinship Parent Bill of Rights, and has a section related to foster parent and kinship parent agreements.

The rights for the foster child include certain basic rights relating to a child's living conditions and well-being, such as the right to food, shelter, clothing, and education. Other examples include: the right to live in a safe healthy environment; the right to receive medical, dental, and vision care; and the right to maintain contact with previous caregivers and other important adults, subject to the reasonable and prudent foster parent standard and approval by the court. There are 21 rights provided to foster children in the bill.

The bill sets forth a Foster Parent Bill of Rights. These rights include being notified in advance of hearings; being provided with information regarding investigations; the right to receive information prior to placement regarding the child's behavior or special needs; the rights to submit a letter or report to the court regarding a violation of the rights or any concerns over the conduct or performance of the guardian ad litem, a representative of the department, or representative of the child placing agency, which the court may act upon; and the right to receive a copy of the agreement between the child placing agency and the department. The clerk is required to circulate this letter to the parties of record. There are 16 rights provided to foster and kinship parents in this bill.

The bill provides that the rights set forth in the bill do not create an independent cause of action and violations may be investigated by the foster care ombudsman. The ombudsman is required to submit a report on the number of complaints received and investigations completed, on December 15th of 2021 and every year thereafter, to the Joint Standing Committee, the Supreme Court, and the Governor.

The bill sets forth requirements for the agreement between the foster or kinship parent, the department, and the child placing agency. The purpose of these requirements is to provide notice to the foster parents regarding their duties and rights. These provisions detail the relationship between the department, the foster parent, the kinship parent, and/or the child placing agency. Some of the rights in the House version of the bill were moved to this section of the bill, including provisions addressing out of state travel, child-care, payment, informing the foster parent of applicable laws, and termination of the placement. New provisions were added, including provisions related to medical care and how to obtain

consent, provisions for addressing how complaints against the foster parent will be handled and appealed, and a provision related to other terms that may be negotiated.

The bill provides that the duties and requirements in the agreement do not create a cause of action or action in breach of contract. The bill provides that violations of these rights may be reported and investigated by the foster care ombudsman.

The bill sets forth the reasonable prudent foster parent standard. This is the standard the caregiver must use to determine whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities. This section permits a foster parent to use persons to care for or baby sit the child or to permit overnight stays outside of the home using the reasonable prudent foster parent standard.

The bill creates a section providing that when a child is removed from his or her home placement, preference must be given to relatives of the child and fictive kin. The department must diligently search for relatives within the first days of removal. It requires that, no later than seven calendar days after the petition for removal has been filed, the department shall file a list of all known relatives and fictive kin of the child with the court.

The bill revises language related to substantiation of child abuse and neglect. The bill sets forth an appeals process and provides for the development of legislative rules.

The bill states that a guardian ad litem shall, in the performance of his or her duties, adhere to the requirements of the Rules of Procedure for Child Abuse and Neglect Proceedings, the Rules of Professional Conduct, and such other rules as the West Virginia Supreme Court of Appeals may promulgate and any appendices thereto. A guardian ad litem must meet all certification and education requirements as a condition for receiving payment.

Finally, the West Virginia Supreme Court of Appeals is requested to provide guidance to the judges of the circuit courts regarding supervision of guardians ad litem. The bill also requests the Supreme Court of Appeals to review the Rules of Procedure for Child Abuse and Neglect Proceedings and the Rules of Professional Conduct specific to guardians ad litem.

CODE REFERENCE: West Virginia Code §49-2-102 and §49-2-104 – repealed; §49-1-206, §49-2-108, §49-2-110, §49-2-111, §49-2-111a, §49-2-112, §49-2-118, §49-2-121, §49-2-124, §49-2-126, and §49-4-604 – amended; §49-2-111c, §49-2-127, §49-2-127a, §49-2-128, §49-2-129, §49-4-601a and §49-4-601b – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4102

Relating to opioid antagonists

The bill permits a licensed health care provider to directly or by standing order prescribe an opioid antagonist to: (a) a person at risk of experiencing an opioid-related overdose: or (b) a family member, friend, or other person in a position to assist a person at risk of experiencing an opioid related overdose. The bill also permits a licensed health care provider to directly or by standing order to prescribe an opioid antagonist to any governmental or non-governmental organization, including local health department, a law enforcement agency, or an organization that promotes scientifically proven way of mitigating health risks associated with substance use disorder to the same individuals discussed previously.

The bill permits a pharmacist to dispense the medication. The bill permits governmental or non-governmental organizations to distribute the medication to individuals noted above. The bill requires education on how to administer the medication. The bill provides limitations of liability for persons acting in good faith in administering the medication to another. The bill permits a person or organization to possess an opioid antagonist regardless of whether the person organization hold a prescription for the medication.

The bill provides that the distribution of an opioid antagonist by governmental or non-governmental entity, granting institution, medical provider or pharmacy whose software cannot automatically report to the controlled substance monitoring database shall report to the West Virginia Office of Drug Control Policy on a monthly basis and prescribe the timeframe and reporting information.

Additionally, making technical changes to the controlled substance monitoring database.

CODE REFERENCE: West Virginia Code §16-46-3, §16-46-6, and §60A-9-4 – amended

DATE OF PASSAGE: March 6, 2020

EFFECTIVE DATE: March 6, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4103

Relating to office of drug control policy

The bill continues the Office of Drug Control Policy within the Department of Health and Human Resources under the direction and supervision of the secretary with the assistance of the State Health Officer. Previously, the supervision of this office was provided by the State Health Officer. The bill makes other technical changes.

CODE REFERENCE: West Virginia Code §16-5T-2 – amended

DATE OF PASSAGE: February 14, 2020

EFFECTIVE DATE: May 4, 2020

ACTION BY GOVERNOR: Signed February 14, 2020

House Bill 4108

Relating generally to certificates of need for health care services

The bill streamlines the certificate of need exemption process. The bill removes the \$1,000 filing fee previously required for the exemption application process. Additionally, the bill removes all references to the hearing process, including a 45-day timeframe to issue a decision; references to prohibiting the authority to hold a hearing on the application; and limiting appeals only to the applicant. These references were removed since an applicant must only submit information to the authority and no decision will be issued.

CODE REFERENCE: West Virginia Code §16-2D-11 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 4, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

House Bill 4161

Making it illegal to scleral tattoo a person

The bill reorganizes definitions and adds a definition for scleral tattooing, which means the practice of producing an indelible mark or figure on the human eye by scarring or inserting pigment on, in or under the fornix, conjunctiva, bulbar conjunctiva, ocular conjunctiva or other ocular surface using needles, scalpels or other related equipment. The bill makes it unlawful for any person to perform or offer to perform scleral tattoo upon a person.

CODE REFERENCE: West Virginia Code §16-38-1 and §16-38-3 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4179

Enacting Recognition of Emergency Medical Services Personnel Licensure Interstate Compact

This bill enacts the Recognition of Emergency Medical Services Personnel Licensure Interstate Compact, entering West Virginia into the compact with all jurisdictions that have also enacted the compact. It states the purpose of the compact and defines terms, such as “member states,” “home states,” and “remote states.”

The bill permits member states to require a license under circumstances not covered by the compact, sets conditions for a home state’s license to authorize practice in a remote state under the compact, and requires member states to recognize licenses issued by another member state under certain circumstances. Among other things, the bill lists the requirements for individuals to exercise the privilege to practice, sets the scope of practice, and makes individuals practicing in remote states subject to the remote state’s laws. The bill authorizes remote states to act against an individual’s privilege to practice within that state under certain circumstances; provides for the effect of license restrictions on compact privileges; and sets the conditions of practicing in a remote state under compact terms. It defines the relationship of the compact to the Emergency Management Assistance Compact and sets terms and requirements for certification of veterans, certain service members, and their spouses. It codifies and recognizes the exclusive power of home states to take adverse action against a license issued by the home state and provides consequences for compact participation if an individual’s license is subject to adverse action by his or her home state.

The bill requires member states to report adverse actions against licenses, authorizes home states to take action against an individual’s privilege to practice within that state, requires a home state EMS authority to investigate and take appropriate action based on reported conduct in a remote state, authorizes alternative programs in lieu of adverse action, and authorizes a member state’s EMS authority to issue subpoenas and certain cease and desist orders. It further establishes the Interstate Commission for EMS Personnel Practice and maintains state sovereign immunity. It provides for Commission membership and voting; requires public annual meetings; authorizes the Commission to prescribe bylaws and rules to govern conduct; and provides for financing for the Commission, by requiring an annual assessment against the state contingent upon funds being appropriated by the Legislature or otherwise being made available.

The bill directs state governments to enforce the compact and take necessary actions to effectuate its purposes and intent. It provides for legal venue in West Virginia and an implementation date for the compact, making any state joining after implementation subject to rules as they exist when the compact is adopted. Finally, it directs the Emergency Medical Services Advisory Council to review decisions of the Commission and authorizes the Emergency Medical Services Advisory Council to make recommendations to the Legislature regarding the compact.

CODE REFERENCE: West Virginia Code §16-56-1 through §16-56-15 – new

DATE OF PASSAGE: February 17, 2020

EFFECTIVE DATE: May 17, 2020

ACTION BY GOVERNOR: Signed March 5, 2020

House Bill 4198

Permitting a person to obtain a 12-month supply of contraceptive drugs

The bill requires an insurer which renews, amends, or delivers a health policy or after January 1, 2021 that provides coverage for contraceptives drugs shall provide coverage for a 12 month refill of contraceptives obtained at one time by the insured after the insured has completed the initial supply unless less is requested.

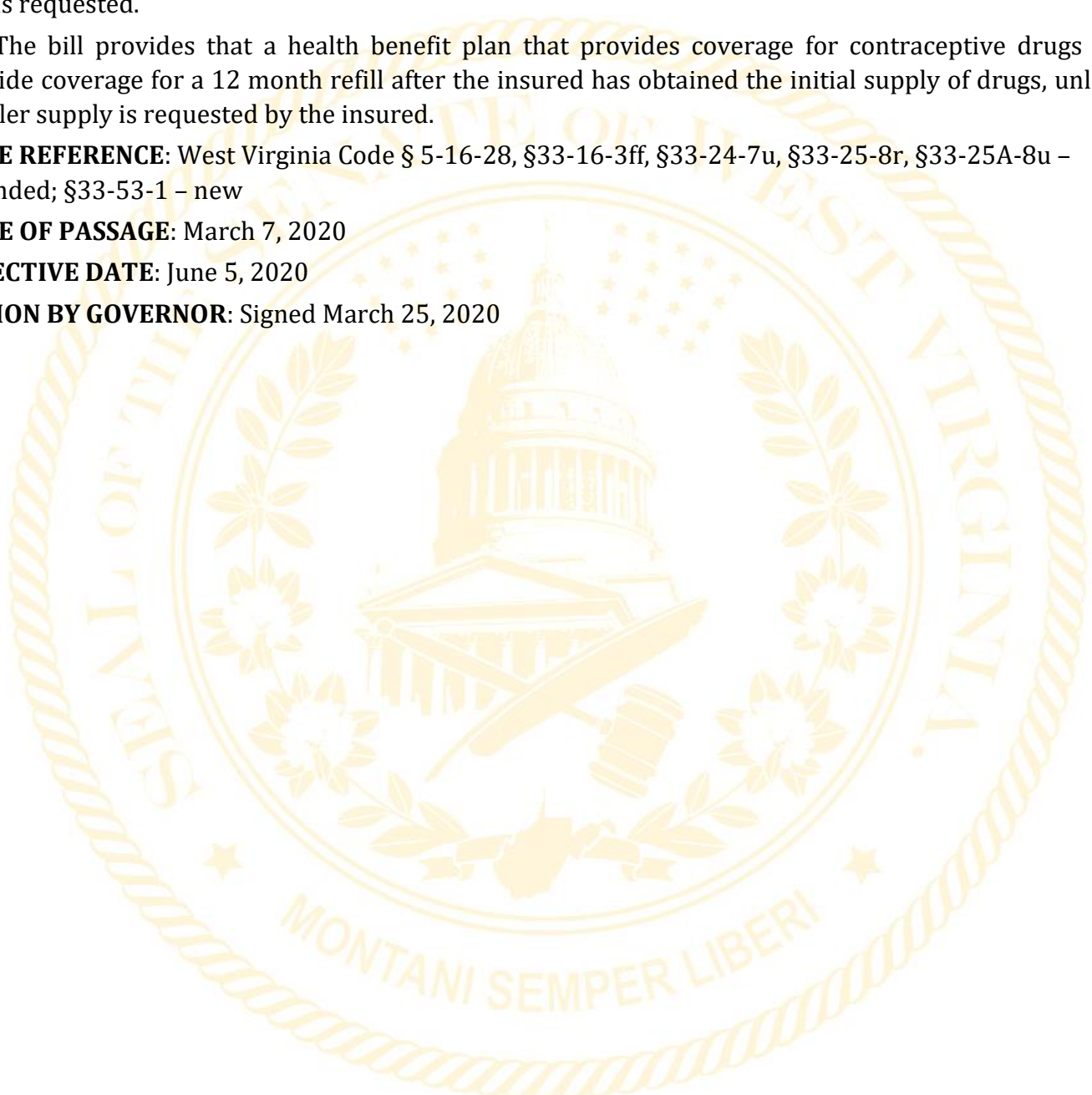
The bill provides that a health benefit plan that provides coverage for contraceptive drugs shall provide coverage for a 12 month refill after the insured has obtained the initial supply of drugs, unless a smaller supply is requested by the insured.

CODE REFERENCE: West Virginia Code § 5-16-28, §33-16-3ff, §33-24-7u, §33-25-8r, §33-25A-8u – amended; §33-53-1 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



House Bill 4252

Authorizing miscellaneous agencies and boards promulgate legislative rules

This bill is known as the miscellaneous rules bundle, which authorizes and directs the promulgation of 80 rules, constituting Bundle 9. Only the legislative rules directly relating to the health care industry are included in this summary.

Board of Acupuncture, Fees of the Board of Acupuncture, 32 CSR 4

The rule amends a current legislative rule. The rule is being modified pursuant to changes made necessary with the passage of House Bill 2324 during the 2019 Regular Session of the Legislature. The bill permitted the Acupuncture Board to issue certificates to perform auricular acudex therapy. Additionally, the bill provided emergency rulemaking authority to the board to establish fees for certificate holders.

The rule establishes a ten-year sunset date, a fee of \$60 for the two-year certificate to perform auricular acudetox therapy, and a fee of \$50 for a two-year renewal of a certificate to perform auricular acudetox.

Board of Acupuncture, Auricular Detoxification Therapy Certificate, 32 CSR 14

There is a new rule which sets out the process for issuance of a certificate, renewal, qualifications and terms for auricular detoxification therapy certification holders. The rule was made necessary with the passage of House Bill 2324 during the 2019 Regular Session.

The rule provides that the certificate is valid for two years. In order to qualify for a certificate an applicant must be at least 18 years old. Additionally, an applicant must be authorized to engage in one of the following licensed professions: physician assistant, dentist, registered professional nurse, practical nurse, psychologist, occupational therapist, social worker, professional counselor, emergency medical services provider, or corrections medical provider. An applicant must provide evidence of successful completion of a board approved auricular acudetox program and submit a completed application and the appropriate fee.

The rule identifies causes for denial, probation, limitation, discipline, suspension, or revocation of the certificate; disciplinary and compliant procedures; and contested case hearing procedures.

Board of Acupuncture, Application for Waiver of Initial Licensing Fees for Certain Individuals, 32 CSR 15

This is a new rule. Senate Bill 396 from the 2019 Regular Session requires boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver. The rule establishes the process and procedure for a first-time licensure applicant that qualifies as a low-income individual or military family to seek a waiver of the initial licensing fee. The rule defines terms, establishes the process for applying for the initial licensing fee waiver, sets forth the eligibility requirements, and describes the necessary information and documents that must be submitted to the Board to process the waiver request and determine eligibility.

Board of Acupuncture, Consideration of Prior Criminal Convictions in Initial Licensure Determinations, 32 CSR 16

This is a new rule which incorporates the necessary changes required by the passage of House Bill 118 during the 2019 First Special Session. It prohibits boards from disqualifying an applicant from initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except for violent or sexual offenses, all to be determined by the board on a case by case basis.

West Virginia Board of Chiropractic, Application For Waiver Of Initial Licensing Fees For Certain Individuals, 4 CSR 7

During the 2019 Regular Session, the Legislature passed Senate Bill 396, which requires each board or licensing authority referred to in Chapter 30 of the West Virginia Code to “waive all initial occupational licensing fees” for military personnel and their spouses, and for low-income individuals in the local labor market.

This new legislative rule establishes procedures for waiving the initial licensing fee for: 1) low income individuals in the local labor market (i.e., in West Virginia or any county outside of West Virginia if any portion of that county is within fifty miles of the border of West Virginia), and 2) military personnel and their spouses, who apply to the West Virginia Board of Chiropractic for a license to practice chiropractic in this state.

West Virginia Board of Chiropractic, Consideration of Prior Criminal Convictions in Initial Licensure Determinations, 4 CSR 8

During the 2019 First Extraordinary Session, the Legislature enacted House Bill 118. The bill specifies the conditions upon which most of the Chapter 30 boards may disqualify an applicant for initial licensure based on a prior criminal conviction.

The bill requires these Chapter 30 boards to permit a person disqualified from initial licensure to again apply for initial licensure five years after the latter of the date of conviction or release from incarceration, if certain other conditions are met. The bill also allows a prospective applicant who has not applied for licensure to ask the appropriate board, by petition, for an advanced determination by the board of whether his or her conviction would disqualify the petitioner from licensure. The board may charge a fee to cover its costs of making the determination.

Board of Counseling, Application for Waiver of Initial Licensing Fees for Certain Individuals, 27 CSR 13

This new rule is in response to Senate Bill 396 from the 2019 Regular Session, which requires boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver for an initial license.

West Virginia Board of Dentistry, Rule for The West Virginia Board of Dentistry, 5 CSR 1

This rule amends a current legislative rule to comply with three bills that passed in 2019. Senate Bill 400 and Senate Bill 396 passed during the Regular Session, and House Bill 118 passed during the First Extraordinary Session. The rule specifies the clinical examinations which must be passed to qualify for licensure as a dentist or dental hygienist and specifies the specialties in dentistry which may be recognized by the Board.

The rule defines low-income individuals and military families and requires those qualified who seek the waiver of an initial licensure fee to practice dentistry or dental hygiene to apply for the waiver in a format prescribed by the Board of Dentistry.

The rule specifies the conditions upon which the board may disqualify an applicant for initial licensure based on a prior criminal conviction. It permits a person disqualified from initial licensure to again apply for initial licensure five years after the latter of the date of conviction or release from incarceration, if certain other conditions are met. It also allows a prospective applicant who has not applied for licensure to ask the appropriate board, by petition, for an advanced determination of whether his or her conviction

would disqualify the petitioner from licensure. The board may charge a \$100 fee to cover its costs of making the determination.

West Virginia Board of Dentistry, Dental Advertising, 5 CSR 8

This rule amends an existing legislative rule. It removes extensive detailed prescriptions for and proscriptions against advertising by dentists. The Board's stated reason is that the provisions in the Dental Practice Act (W. Va. Code §30-4-1, et seq.) are sufficient to regulate advertising.

Board of Dieticians, Licensure and Renewal Requirements, 31 CSR 1

This rule amends a current legislative rule to incorporate the provisions of House Bill 118, which passed during the 2019 First Extraordinary Session, prohibiting many licensing boards from disqualifying an applicant for licensure because of a prior criminal conviction unless that conviction is for a crime that bears a rational nexus to the profession or occupation requiring licensure.

Board of Dieticians, Application for Waiver of Initial Licensing Fees for Certain Individuals, 31 CSR 6

This new rule implements Senate Bill 396, which passed during the 2019 Regular Session, requiring boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver. The rule establishes the process and procedure for first time licensure applicants that qualify as a low-income individual or military family to seek a waiver of the initial licensing fee.

Hearing Aid Dealers, Application for Waiver of Initial Licensing Fees for Certain Individuals, 8 CSR 4

This new rule implements the requirements of Senate Bill 396, which passed during the 2019 Regular Session. It requires professional licensing boards regulated under Chapter 30 to waive initial licensure fees for low-income persons and military families.

Hearing Aid Dealers, Consideration of Prior Criminal Convictions in Initial Licensure Decisions, 8 CSR 5

This new rule is required due to the passage of House Bill 118 during the 2019 First Special Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except for violent or sexual offenses, all to be determined by the board on a case by case basis.

West Virginia Medical Imaging and Radiation Therapy Technology Board of Examiners, West Virginia Medical Imaging and Radiation Therapy Technology Board of Examiners, 18 CSR 1

The rule amendment by the West Virginia Medical Imaging and Radiation Therapy Technology Board of Examiners (the Board) implements the requirements of Senate Bill 118, which passed during the 2019 First Extraordinary Session; implements the requirements of Senate Bill 392, which passed during the 2019 Regular Session; and makes a number of modifications to general licensing requirements.

The amendments to general licensing requirements include:

- The Board has clarified that an expired license is classified as "inactive" after the passage of 60 days from the expiration date. A person with an inactive license must apply for reinstatement rather than complete a simpler renewal process. An applicant for reinstatement must demonstrate compliance with continuing education requirements and national certification;
- The Board is now requiring that payment of all fees be completed by electronic means;

- The Board has clarified that continuing education requirements and license reinstatement fees for military families must be waived while a service member is on active duty, as required by W. Va. Code §30-1B-3;
- The Board has clarified that a licensee or permittee must notify the Board within 30 days of a change of name or contact information;
- The Board has changed the requirement that a license be prominently displayed in a technologist's place of work to a requirement that the licensee produce documentation of licensure upon request. The board also permits technologists to produce photocopied and faxed documentation of licensure for employment verification purposes; and
- The Board prohibits discrimination based on a person's membership in a protected class according to applicable state and federal laws, rather than listing protected classes.

Board of Medicine, Licensure, Disciplinary and Complaint Procedures, 11 CSR 01B

This rule amends a current legislative rule. It includes an entirely new streamlined procedural system called "practice notifications" for the regulation of hospital-based physician assistance practice as required by Senate Bill 668, which passed during the 2019 Regular Session. It also includes a modification of the role of a collaborating physician across different practice settings; clarifies prescriptive authority across practice settings; and adds a prohibition against permitting an employment relationship to affect professional roles, judgement, or patient care.

Board of Medicine, Waiver of Initial Licensing Fees for Certain Initial Licensure Applicants, 11 CSR 13

This new rule establishes the process and procedure for a first-time licensure applicant that qualifies as a low-income individual or military family to seek a waiver of the initial licensing fee. The rule defines terms, establishes the process for applying for the initial licensing fee waiver, sets forth the eligibility requirements, and describes the necessary information and documents that must be submitted to the Board to process the waiver request and determine eligibility.

West Virginia Nursing Home Administrators Licensing Board, West Virginia Nursing Home Administrators Licensing Board, 21 CSR 1

This rule amends a current legislative rule to incorporate the provisions of House Bill 118, which passed during the 2019 First Extraordinary Session, prohibiting many licensing boards from disqualifying an applicant for licensure because of a prior criminal conviction unless that conviction is for a crime that bears a rational nexus to the profession or occupation requiring licensure.

Senate Bill 396, which passed during the 2019 Regular Session, requires boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver. The rule establishes the process and procedure for first time licensure applicants that qualify as a low-income individual or military family to seek a waiver of the initial licensing fee.

West Virginia Board of Occupational Therapy, Fees For Services Rendered By The Board, 13 CSR 3

This rule amends a current legislative rule. It reduces the annual fee for a license to practice as an occupational therapist from \$140 to \$120. It reduces the annual fee for a license to practice as an occupational therapy assistant from \$120 to \$100.

The rule eliminates "application packet" and "paper list" fee and reduces the "mailing labels" fee from \$110 to \$15.

West Virginia Board of Occupational Therapy, Application for Waiver Of Initial Licensing Fees For Certain Individuals, 13 CSR 7

This is a new rule. During the 2019 Regular Session, the Legislature passed Senate Bill 396, which requires each board or licensing authority referred to in Chapter 30 of the West Virginia Code to “waive all initial occupational licensing fees” for military personnel and their spouses and for low-income individuals in the local labor market.

The rule establishes procedures for waiving the initial licensing fee for 1) low income individuals in the local labor market (i.e., in West Virginia or any county outside of West Virginia if any portion of that county is within fifty miles of the border of West Virginia), and 2) military personnel and their spouses, who apply to the West Virginia Board of Occupational Therapy for a license to practice as an occupational therapist or an occupational therapy assistant in this state.

West Virginia Board of Occupational Therapy, Consideration of Prior Criminal Convictions in Initial Licensure Determinations, 13 CSR 8

This is a new rule. During the 2019 First Extraordinary Session, the Legislature enacted House Bill 118. The bill specifies the conditions upon which most of the Chapter 30 boards may disqualify an applicant for initial licensure based on a prior criminal conviction. The bill requires these Chapter 30 boards to permit a person disqualified from initial licensure to again apply for initial licensure five years after the latter of the date of conviction or release from incarceration, if certain other conditions are met.

The bill also allows a prospective applicant who has not applied for licensure to ask the appropriate board, by petition, for an advanced determination by the board of whether his or her conviction would disqualify the petitioner from licensure. The board may charge a fee to cover its costs of making the determination.

West Virginia Board of Optometry, Rules of the West Virginia Board of Optometry, 14 CSR 01

This rule amends a current legislative rule. The modifications to this rule incorporate the provisions of Senate Bill 396 passed during the 2019 Regular Session of the Legislature. That bill provided for a waiver of initial licensing fees for low-income and military individuals by all Chapter 30 professional licensing boards.

West Virginia Board of Osteopathic Medicine, Osteopathic Physician Assistants, 24 CSR 02

This rule amends a current legislative rule. The changes were made necessary by the passage of Senate Bill 668 during the 2019 Regular Session.

The rule regulates the licensure, regulation, and discipline of osteopathic physician assistants (PA). It contains requirements for practice, licensing requirements, practice agreements and the requirements of the Board, physicians, and physician assistants pursuant to these agreements. The rule also contains the procedure for disciplinary actions against a physician assistant. The rule establishes that a physician assistant may not practice independently and is required to be in a collaborative relationship with a licensed physician. It contains provisions regarding a collaborating physician’s practice agreement and alternate collaborating physicians.

A new section has been added regarding practice notifications. This section requires that a practice notification be filed with the Board. It is required to be on a form provided by the Board and should be accompanied by a fee of \$100. Before the physician assistant may begin practicing, he or she is required to receive a written notice from the Board. This section also sets out the required elements to be included in the practice notification.

Additionally, this section allows the hospital to place limitations on a PA with a restricted license. It also sets out the conditions which make a practice notification complete, and when a PA may start practice upon receipt of written notice from the Board. There are limitations on where a PA may practice based on the parameters set forth in the practice notification. The rule provides for conditions when a practice notification automatically terminates, including when a license expires and when practice in the hospital is terminated with notice, due to lack of proper credentialing. The rule provides that a PA may practice under one or more practice notifications simultaneously.

The extent of the prescriptive authority of a PA is set out in the rule. There is an exception to the statutory limits if a medication is administered by a PA in a hospital setting pursuant to physician orders. Charting of medication is required. The information required on a prescription ordered by an PA, either written or electronic, is set out in the rule. Finally, prescriptions issued by a PA are limited to those identified in the practice notification.

The final new section pertains to the responsibilities of physicians collaborating with physician assistants in hospitals pursuant to practice notifications. The section requires hospital approval prior to collaboration in a hospital setting. The physician is required to oversee and direct the work of the PA and this work must be within the PA's scope of practice and suitable for the PA to perform based upon his or her training and education. It also requires that the physician and the PA be in contact with one another either electronically or in person.

West Virginia Board of Osteopathic Medicine, Waiver of Initial Licensing Fees for Certain Initial Licensure Applicants, 24 CSR 08

This is a new rule which incorporates the provisions of Senate Bill 396, which passed during the 2019 Regular Session. That bill provided for a waiver of initial licensing fees for low-income and military individuals by all Chapter 30 professional licensing boards.

Board of Pharmacy, Licensure and Practice of Pharmacy, 15 CSR 1

This rule amends a current legislative rule. It extends the time a pharmacy has to produce information regarding a transfer of prescription drugs without a prescription to another licensee from 48 hours to 72 hours. It also permits a pharmacy intern to transfer a prescription to another pharmacy for a patient, but not a scheduled drug.

The rule updates compounding standards to the United States Pharmacopeia Convention, which are incorporated by reference. The rule removes the requirement that a pharmacist wear a white coat. Finally, the rule updates emergency dispensing standards in accordance with House Bill 2524, which passed during the 2019 Regular Session, permitting the dispensing of a 72-hour supply.

Board of Pharmacy, Record Keeping and Automated Data Processing, 15 CSR 4

This rule amends a current legislative rule. It increases the amount of time that a pharmacy has to produce records from 48 to 72 hours, removes the specific data a pharmacist should review concerning a patient's history, adds the statement that the pharmacist shall review any data needed to make a rational judgement about pharmacist care, removes outdated language concerning the keeping of a log book by a pharmacist instead of an electronic system, and adds a schedule V throughout as a controlled substance.

Board of Pharmacy, Board of Pharmacy Rules for Registration of Pharmacy Technicians, 15 CSR 7

This rule amends a current legislative rule. It implements the provisions of House Bill 2849, which passed during the 2019 Regular Session, establishing different classes of pharmacy technicians. This

includes adding functions to the pharmacy technician's scope of practice and establishing a nuclear pharmacy technician endorsement and scope.

The rule clarifies that applicants cannot be disqualified from initial licensure unless the crime bears a rational nexus to the practice of pharmacy.

Board of Pharmacy, Immunizations Administered by Pharmacists and Pharmacy Interns, 15 CSR 12

This rule amends a current legislative rule. The rule concerns immunizations administered by pharmacists and pharmacy interns. The age limit for parental consent was incorrect, so the board adjusted it to the correct age, which is 17.

Board of Pharmacy, Board of Pharmacy Rules for Centralized Prescription Processing, 15 CSR 14

This rule amends a current legislative rule. The rule relates to centralized prescription processing. The rule prohibits a schedule II drug from being filled at a centralized prescription processing center.

Board of Pharmacy, Regulations Governing Pharmacy Permits, 15 CSR 15

This rule amends a current legislative rule which regulates pharmacies. The rule modernizes and updates the regulation of pharmacies by providing standard registration language, changing permits from annually to biennially and doubling fees accordingly, and updating the surrender of registration process.

Board of Pharmacy, Regulations Governing Pharmacists, 15 CSR 16

This rule amends a current legislative rule to incorporate the provisions of House Bill 118, which passed during the 2019 First Extraordinary Session. The rule prohibits disqualifying an applicant for licensure because of a prior criminal conviction unless that conviction is for a crime that bears a rational nexus to the profession or occupation requiring licensure. The bill also prohibits boards from disqualifying an applicant for licensure based on a prior conviction of a crime generally described as one of "moral turpitude."

Board of Pharmacy, Application for Waiver of Initial Licensing Fees for Certain Individuals, 15 CSR 18

This new rule incorporates the provisions of Senate Bill 396, which passed during the 2019 Regular Session. That bill provided for a waiver of initial licensing fees for low-income and military individuals by all Chapter 30 professional licensing boards.

Physical Therapy, General Provisions for Physical Therapists and Physical Therapist Assistants, 16 CSR 01

This rule amends a current legislative rule to comply with the passage of Senate Bill 1006 and House Bill 118 during the 2019 First Extraordinary Session. Amendments include a criminal background check requirement; compliance with a rational nexus test for prior convictions; permissive language for physician referral to an appropriate health care provider if services are beyond the scope of the practice of physical therapy; modification to the English proficiency language; granting the Board the right to conduct random continuing education audits; licensing individuals outside the United States; and continuing education requirements.

Physical Therapy, Fees for Physical Therapists and Physical Therapists Assistants, 16 CSR 04

This rule amends a current legislative rule to implement the provisions of Senate Bill 633, which passed during 2019 the Regular Session. This rule creates a fee of \$50 for a physical therapy compact and a fee of \$200 for continuing education noncompliance.

Physical Therapy, General Provisions for Athletic Trainers, 16 CSR 05

This rule amends a current legislative rule which is required as a result of the passage of Senate Bill 60 during the 2019 Regular Session. Amendments include additional definitions and modifications to existing definitions. It also identifies new requirements for the application process, including providing educational information, previous work experience, and a completed criminal background check. Several new requirements for the practice of the athletic training have been added, including requirements for the issuance, renewal, or reinstatement of licenses; a criminal history record check; temporary permit for athletic trainers; the scope of practice for the athletic trainer; the athletic training student and/or permittee; licensing individuals outside of the United States; and continuing education.

Physical Therapy, Fees for Athletic Trainers, 16 CSR 06

This rule amends a current legislative rule which sets fees for athletic trainers. The rule implements changes made necessary by the passage of Senate Bill 60, which passed during the 2019 Regular Session. The following fees were increased: Athletic Trainer License, from \$100 to \$180, and a Renewal Fee, from \$75 to \$80.

The following new fees were created: Athletic Trainer Temporary Permit, \$30; Duplicate Wall License Card, \$5; Continuing ED Course Review, \$50; and Individual Licensee Review, \$15. Language was also added to reference the Code regarding low income and military waivers for initial licenses.

Physical Therapy, Application for Waiver of Initial Licensing Fees for Certain Individuals, 16 CSR 09

This new rule establishes the process and procedure for first time licensure applicants that qualify as a low-income individual or military family to seek a waiver of the initial licensing fee. This rule is being added to comply with Senate Bill 396, which passed during the 2019 Regular Session, waiving initial license fees for certain individuals.

Board of Psychologists, Consideration of Prior Criminal Convictions in Initial Licensure Determinations, 17 CSR 07

This rule amends a current legislative rule in response to the passage of House Bill 118 during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except for violent or sexual offenses, all to be determined by the board on a case by case basis. The fee for an applicant petitioning for a licensure eligibility determination is \$75 and is offset against the application fee.

It also incorporates the changes required by Senate Bill 396, which passed during the 2019 Regular Session, requiring boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver.

West Virginia Board of Examiners for Registered Professional Nurses, Requirements for Registration and Licensure And Conduct Constituting Professional Misconduct, 19 CSR 3

This rule amends a current legislative rule in response to the passage of House Bill 118 during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except violent or sexual offenses, all to be determined by the board on a case by case basis. It also incorporates the changes required by Senate Bill 396 from 2019 Regular Session, which requires boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver.

West Virginia Board of Examiners For Registered Professional Nurses, Application For Waiver Of Initial Licensing Fees For Certain Individuals, 19 CSR 15

This new rule implements the provisions of Senate Bill 396, which passed during the 2019 Regular Session, requiring boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver.

The rule establishes procedures for waiving the initial licensing fee for 1) low income individuals in the local labor market (i.e., in West Virginia or any county outside of West Virginia if any portion of that county is within fifty miles of the border of West Virginia), and 2) military personnel and their spouses, who apply to the West Virginia Board of Examiners For Registered Professional Nurses for a license to practice registered professional nursing or advanced practice registered nursing in this state.

Respiratory Care, Establishment of Fees, 30 CSR 02

This rule amends a current legislative rule to incorporate the provisions of Senate Bill 396, which passed during the 2019 Regular Session, requiring boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver.

Respiratory Care, Student Temporary Permit, 30 CSR 09

This rule amends a current legislative rule decreasing the payment of the permit renewal fee from \$40 dollars to \$25 dollars. The rule also permits current student/ temporary graduate permit holders to work through the expiration date of their student permit.

Respiratory Care, Consideration of Prior Criminal Convictions in Initial Licensure Determinations, 30 CSR 10

This new rule sets forth a procedure for the consideration of prior criminal convictions in initial licensure determinations. The rule is created as a result of the passage of House Bill 118, during the 2019 First Extraordinary Session, which set forth criteria for licensing boards to consider in making an initial licensure determination.

Social Work Examiners, Qualifications for the Profession of Social Work, 25 CSR 1

This rule amends a current legislative rule in response to the passage of House Bill 118 during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except violent or sexual offenses, all to be determined by the board on a case by case basis.

Social Work Examiners, Fee Schedule, 25 CSR 3

This rule amends a current legislative rule implementing the provisions of Senate Bill 396, which passed during the 2019 Regular Session, providing that low-income and military family applicants may

apply for a waiver of initial license fees if they meet the requirements for licensure and the statutory qualifications for “low-income individuals” or “military families.”

Speech Language Pathology and Audiology, Licensure of Speech-Pathology and Audiology, 29 CSR 01

This rule amends a current legislative rule implementing the provisions of Senate Bill 396, which passed during the 2019 Regular Session, providing that low-income and military family applicants may apply for a waiver of initial license fees if they meet the requirements for licensure and the statutory qualifications for “low-income individuals” or “military families.”

The rule also requires verification of continuing education credits to be submitted as part of the license reinstatement renewal process; provides a biennial renewal for retired licenses; provides that the Board may grant an exemption for continuing education requirements in certain circumstances, such as extended illness; requires the licensee to attest to the completion of the required continuing education on the renewal form; requires the licensee to retain all continuing education documents for four years after the date of renewal; and gives the Board the ability to audit licenses for continuing education compliance.

The rule also clarifies that the waiver of renewal fees applies to active duty military families, as required by House Bill 118, which passed during the 2019 First Extraordinary Session.

Speech Language Pathology and Audiology, Disciplinary & Complaint Procedures for Speech-Language Pathology and Audiology, 29 CSR 04

This rule amends a current legislative rule setting forth a procedure for the investigation and resolution of complaints against speech-language pathologists, audiologists, provisional licensees, and assistants. The rule also states causes for denial, probation, limitation, discipline, suspension, or revocation of licenses.

The rule is also amended to comply with House Bill 118, which passed during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except violent or sexual offenses, all to be determined by the board on a case by case basis. The fee for an applicant petitioning for a licensure eligibility determination is \$100 and is offset against the application fee.

Veterinary Medicine, Organization and Operation and Licensing of Veterinarians, 26 CSR 01

This rule amends a current legislative rule to establish guidelines for the organization and operation of the Board of Veterinary Medicine and for the licensing of veterinarians by the Board. This rule is being amended to comply with House Bill 118, which was passed during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except violent or sexual offenses, all to be determined by the board on a case by case basis.

Veterinary Medicine, Registration of Veterinary Technicians, 26 CSR 03

This rule amends a current legislative rule to establish the procedures by which Veterinary Technicians may be registered and regulated by the West Board of Veterinary Medicine. This rule is being amended to comply with House Bill 118, which was passed during the 2019 First Extraordinary Session. It prohibits boards from disqualifying applicants for initial licensure because of a prior criminal conviction unless the crime bears a rational nexus to the profession, except violent or sexual offenses, all to be determined by the board on a case by case basis.

Veterinary Medicine, Schedule of Fees, 26 CSR 06

This rule amends a current legislative rule to establish the procedures by which Veterinary Technicians may be registered and regulated by the West Virginia Board of Veterinary Medicine. This rule incorporates the provisions of Senate Bill 396, which passed during the 2019 Regular Session, requiring boards to update fee schedules to allow low-income individuals and military families to apply for a fee waiver.

The rule creates a veterinary technician inactive registration fee of \$2, a fee for veterinary technician inactive license reactivation fee of \$6, a fee for a veterinary ambulatory inspection of \$200, and a fee for a predetermination for veterinarian or veterinarian technician licensure eligibility of \$150. The rule also reduces the veterinarian technician registration fee from \$100 to \$10 and the veterinarian technician renewal fee from \$80 to \$5.

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: March 6, 2020

EFFECTIVE DATE: March 6, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



House Bill 4354

Adding nabiximols to the permitted list of distributed and prescribed drugs

The bill provides for the sale, wholesale, distribution, or prescribing of nabiximols in a product approved by the Food and Drug Administration and provides that nabiximols shall be placed on the schedules of controlled substances or descheduled as provided by the Drug Enforcement Administration.

CODE REFERENCE: West Virginia Code §60A-2-201 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 4, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

House Bill 4375

Speech-Language Pathologists and Audiologists Compact

This bill enters the state of West Virginia into the Audiology and Speech-Language Pathology Compact and facilitates interstate practice of audiology and speech-language pathology services.

The bill contains provisions for the following:

- Definitions;
- State participation in the compact;
- Establishing the privilege to practice in member states;
- Procedures relating to licensing for active duty military personnel and their spouses;
- Procedures relating to adverse actions;
- Establishing the Audiology and Speech-Language Pathology Compact Commission;
- A data system available for use among the member states;
- Rule-making authority of the Commission;
- Oversight, dispute resolution, and enforcement provisions of the Commission among the member states;
- Date of implementation among the member states;
- Applicability of the existing rules at the time a new member state joins the Commission;
- Withdrawal of any member states and conditions that must be met until withdrawal is effective;
- A six-month period before withdrawal is effective;
- Construction and severability of the provisions of the Compact; and
- A binding effect of the laws and rules of the Compact among the member states.

CODE REFERENCE: West Virginia Code §30-32A-1 through §30-32A-14 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4422

The Patient Brokering Act

The purpose of the bill is to prohibit patient brokering. The bill provides definitions. The bill defines health care providers or health care facilities as any person or entity licensed or certified or authorized by law to provide professional health care service in this state to a patient during the patient's medical, remedial or behavioral health care health care, treatment or confinement. The bill defines health care provider network entity as a corporation, partnership, or limited liability company owned or operated by two or more health care providers and organized for the purpose of entering into agreements with health insurers, health care purchasing groups, or the Medicare or Medicaid program. Health insurer is defined as any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or causality insurance in the state that is offering a minimum premium plan or stop loss coverage for any person or entity providing health care benefits, any self-insurance plan.

The bill makes it unlawful for any person, including a health care provider, or health care facility to offer to pay a commission or solicit or receive a commission benefit, bonus, rebate, kickback, or bribe directly or indirectly, in cash or in kind, or engage in any split-fee arrangement, in any form whatsoever, to induce the referral of a patient to or from a health care provider or health care facility, for the acceptance or acknowledgement of treatment from a health care provider or health care facility or aid, abet or otherwise participate in the conduct prohibited under this subsection. The bill also makes it unlawful to engage in any of the unlawful acts provided for in W.Va. Code §16-59-1 regarding recovery residences.

The bill provides for penalties upon conviction including a felony conviction and penalties. The penalties begin at \$50,000 for conduct involving 10 or more patients the fine shall not be more than \$100,000.

The bill provides for exceptions. The bill does not apply to any discount, payment, waiver of payment or payment practice expressly authorized by 42 U.S.C. §1320-7b(b)(3) or applicable regulations. The bill provides an exemption for any payment, compensation, or financial arrangement within a group practice provided this payment, compensation, or arrangement is not to or from persons who are not members of the group practice. It provides an exemption for payments to a health care provider or health care facility for professional consultation services, commissions, fees or other remuneration lawfully paid to insurance agents. There is an exemption for payments by a health insurer who reimburses, provides, offers to provide or administers health, mental health, or substance abuse goods or services under a health benefit plan. An exemption exists for payments to or by a health care provider or health care facility, or health care provider network entity that has contracted with a health insurer, a health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health plan when the payments are for goods or services under the plan. An exemption exists for insurance advertising and promotional gifts and commissions or fees paid to a person or entity providing a referral services to nurses which provide health care services.

An exemption exists for payments by a health care provider or health care facility to a health, mental health, or substance abuse information service that provides information upon request and without charge to consumer about provider of health care good or services to enable consumers to select providers or facilities. To qualify for this exemption, the information service must not attempt to steer or lead a consumer to consider a selection of particular health care providers or entities, it must not provide or represent itself as providing diagnostic or counseling services or assessments of illness, must not provide

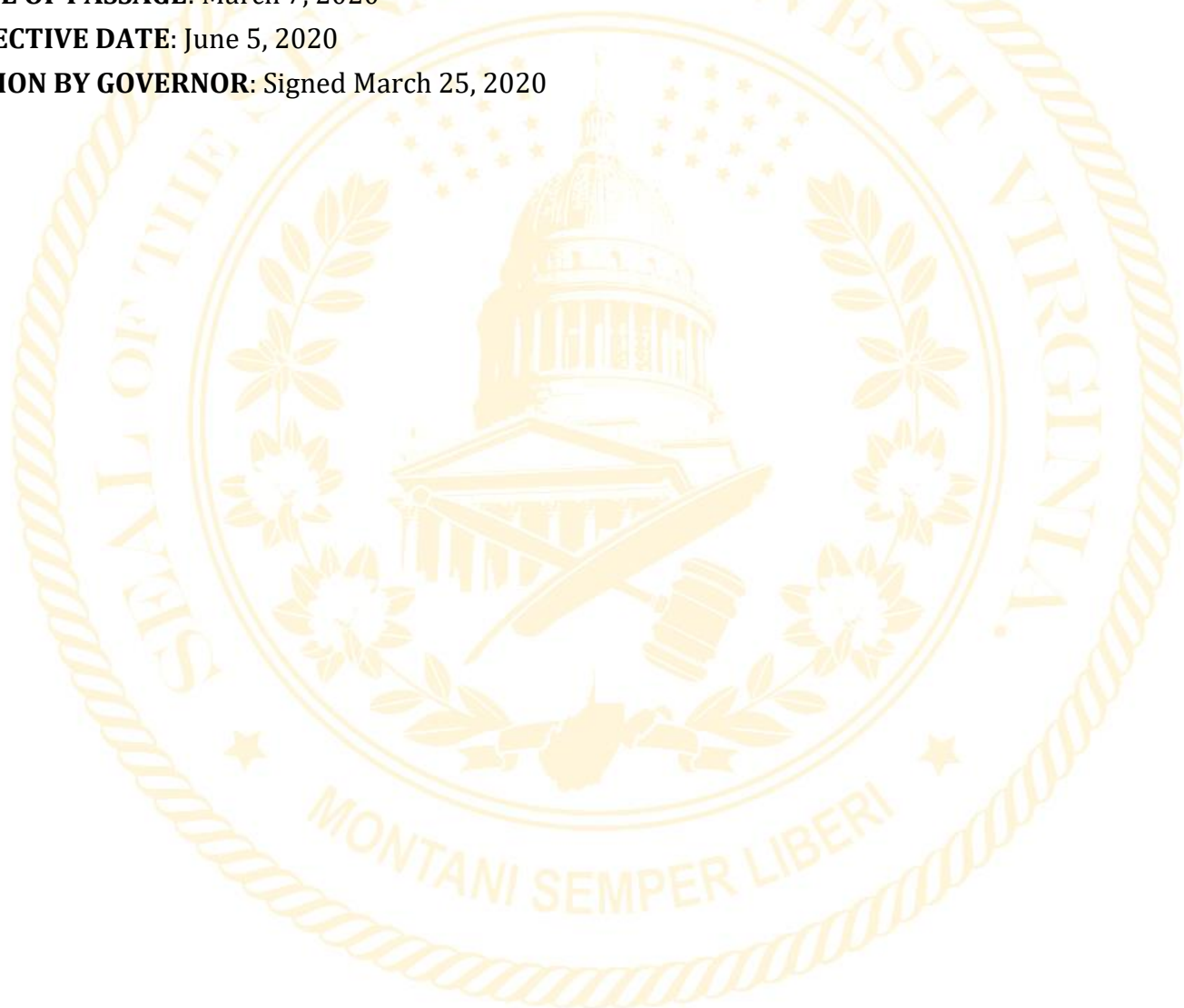
or arrange transportation; and must charge and collect fees from a health care provide or health care facility participating in its services set in advance that are consistent with fair market value for the information services and are not based upon the value of the potential value of patient referrals for goods or services. An exemption exists for payments made by an assisted living facility to an individual employed by the assisted living facility or with whom the facility contracts to provide marketing services for the facility, if the individual clearly indicates that he or she works with or for the facility. Finally, an exemption exists for payments made to a resident of an assisted living facility who refers a friend, family members or other individuals with who the resident has a personal relationship to the assisted living facility, in which case the assisted living facility may provide monetary reward to the resident for making the referral.

CODE REFERENCE: West Virginia Code §16-59-1, §16-59-2, and §16-59-3 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



House Bill 4434

West Virginia health care workforce sustainability study

The bill creates a study of the healthcare workforce and directs the Department of Commerce to issue a report, sets forth the contents of the report, requires certain entities to report, sets forth the contents of the report and deems information received by the department to be confidential trade secrets exempt from disclosure.

The bill defines the continuum of care as the following health care providers or facilities: assisted living residence, behavioral health service, hospice, hospitals, home health agency, skilled nursing facility/nursing home, and emergency medical service agency.

The bill requires the Secretary of Department of Commerce to research, survey, study and issue a public report on the existing workforce in the continuum of care, as well as the anticipated future works needs over the next 15 years. The bill requires that the report shall be publicly available and provided to LOCHHRA.

The bill permits the Secretary to obtain grants to facilitate research, survey and study and permits the Secretary to enter into agreements with governmental agencies, committees, research divisions, including educational institutions. Any and all agreements, grants or contracts for the assistance or sharing of information shall include confidentiality provisions.

The bill provides that the report shall not identify any specific entities, providers or facilities nor make specific correlations between any entity, provider or facility and the workforce numbers at an entity, provider or facility.

The bill provides the department is authorized to seek and specifically request information from an entity, government agency, health care provider, health care facility, or private third party, provided that the department shall only request information reasonably designed to elicit the information that is sought by this bill.

The bill provides that department shall research, survey, and study the following aspects of the continuum of care workforce:

- the number of individuals employed;
- the number of full-time and part-time individuals so employed;
- the number of contract, agency, or traveling nurse or specialist utilized;
- the number of vacancies;
- the number of employee separations;
- the number of new graduate employee separations;
- the average number of patients/residents treated at each entity;
- the overall number of individuals licensed, certified, or registered by the state to work in the health care continuum;
- the current rate of licensure, certification, or registration by the state to work on the health care continuum;
- the anticipated growth in the number of individuals that will be licensed, certified or registered in the state to work in the continuum of care over the next 15 years
- the availability of classes of courses offered by secondary, vocational, technical, community, and higher education schools or institutions to train those necessitating licensure, certification, or registration to work in the health care continuum; and

- the average number of graduates per year in those classes or courses offered to train those necessitating licensure, certification or registration to work in the health care continuum.

The bill provides the types of professional that shall be analyzed, to include the following: assisted living, behavioral health, hospice, hospital, home health, skilled nursing/nursing home, and emergency medical service agency.

The bill sets for the direct care or indirect care are physicians, physician assistant, advance practice registered nurse, licensed professional registered nurse, nurse aide, medical assistant, dietician, social worker, physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, speech therapist, respiratory therapist, psychologist, MDS/coding specialist, pharmacist, pharmacist, pharmacy technician, radiologic technician, and emergency medical services personnel.

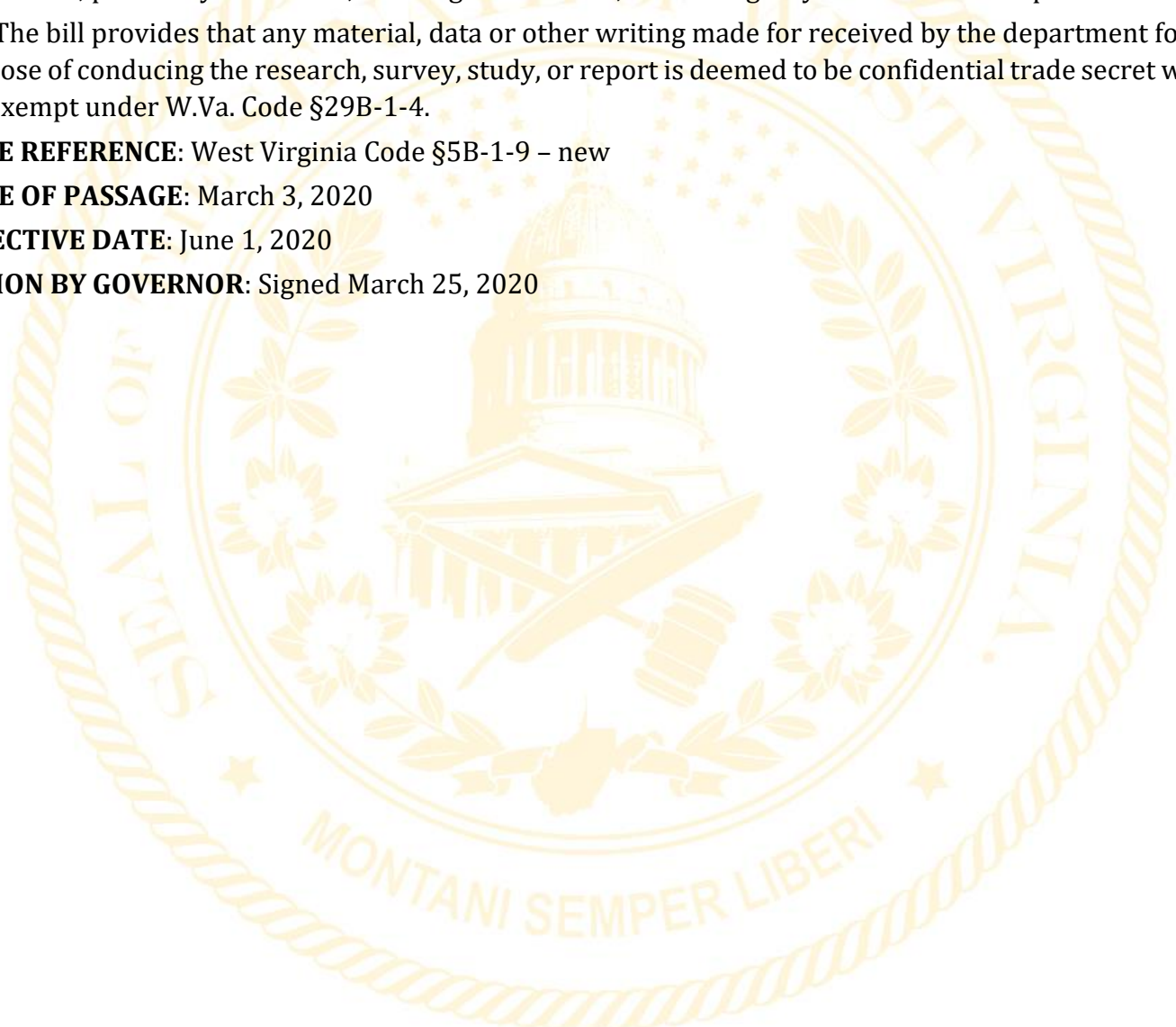
The bill provides that any material, data or other writing made for received by the department for the purpose of conducting the research, survey, study, or report is deemed to be confidential trade secret which are exempt under W.Va. Code §29B-1-4.

CODE REFERENCE: West Virginia Code §5B-1-9 – new

DATE OF PASSAGE: March 3, 2020

EFFECTIVE DATE: June 1, 2020

ACTION BY GOVERNOR: Signed March 25, 2020



House Bill 4494

Tobacco Use Cessation Initiative

This bill creates a task force to undertake studies to monitor and advise the Division of Tobacco Prevention and recommend policies to the Legislature. The bill creates the Division of Tobacco Prevention (Division) within the Bureau of Public Health and sets forth its duties and authorizes the Division to apply for grants.

The Division is created for the purpose of recommending and monitoring the establishment and management of programs that are found to be effective in the reduction of tobacco, tobacco products, alternative nicotine products and vapor products used by all state citizens, with a strong focus on the prevention of children and young adults' use of tobacco, tobacco products, alternative nicotine products, and vapor products.

The bill sets forth the task force members to include, the Commissioner of the Bureau of Public Health, the Superintendent of the Department of Education and 10 members appointed by the Governor.

The bill provides the task force shall meet quarterly at the call of the chair to study, monitor and recommend funding and initiation of programs that reduce tobacco, tobacco products, alternative nicotine products and vapor products consumption in West Virginia and to initiate studies and processes to provide the most efficient and effective use of the funds dedicated for this purpose.

The bill provides that the task force shall report annually to LOCHHRA by December 1st and sets forth the reporting requirements, which include: 1) an assessment of each program administered by the Division of Tobacco Prevention towards reducing the consumption of tobacco, tobacco products, alternative nicotine products and vapor products, and include an overview of its budget for the prior year and how state moneys and any other funding or grants received by the office are being expended; 2) review and analysis of the types of tobacco, tobacco products, alternative nicotine products, and vapor products consumption practices in the state and identify emerging trends related to tobacco, tobacco products, alternative nicotine products, or vapor products delivery devices and related activities impacting tobacco, tobacco, products, alternative nicotine products and vapor products use with emphasis on youth consumption; and, 3) recommend legislation or implementation of public policies.

CODE REFERENCE: West Virginia Code §16-9G-1 and §16-9G-2 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

House Bill 4543

Relating to insurance coverage for diabetics

The bill applies to PEIA and an insurer subject to W.Va. Code §33-15-1 et seq., §33-16-1 et seq., §33-24-1 et seq., §33-25-1 et seq., and §33-25A-1 et seq.

The bill provides that cost sharing for a 30-day supply of a covered prescription insulin drug shall not exceed \$100 for a 30-day supply, regardless of the quantity or type of prescription insulin used to fill the covered person's prescription needs.

The bill states that no contract between an insurer or its pharmacy benefits manager or contracting manager shall contain a provision that authorizes the insurers, the PBM, or pharmacy to charge, requires the pharmacy to collect or requires the covered person to make a cost-sharing payment (co-insurance, deductible, copayment) for a covered prescription insulin drug that exceeds the amount specified above.

The bill mandates coverage for the following equipment and supplies for the treatment of diabetes for both insulin dependent and noninsulin dependent persons: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

The bill mandates coverage for diabetes self-management to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes. The bill further mandates coverage for diabetes self-management to be provided by a health care practitioner.

The bill states that all health plans must offer an appeal process for persons who are not able to take one or more of the offered prescription insulin drugs noted in the bill.

There is a provision in the bill that provides a pharmacy benefits manager, a health plan, or any other third party shall not reimburse a pharmacy at a lower rate and shall not assess any charge back or adjustment upon a pharmacy on the basis that a covered person's cost sharing is being impacted.

CODE REFERENCE: West Virginia Code §33-15C-1 and §33-16-16 – repealed; §5-16-7g and §33-53-1 – new

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: March 7, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4557

Relating to centers and institutions that provide the care and treatment of mentally ill or intellectually disabled individuals

The bill permits the DHHR Secretary to impose a civil monetary penalty, suspend or revoke the license of any behavioral health center for good cause after reasonable notice as provided in legislative rule. The bill also permits the Secretary to impose a civil monetary penalty, suspend or revoke the license of a group residential facility. The bill requires the Secretary to propose rules and has technical clean up language.

CODE REFERENCE: West Virginia Code §27-9-1 and §27-17-3 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4573

Relating to Medicaid subrogation liens of the Department of Health and Human Resources

The purpose of this bill is to harmonize Medicaid subrogation law with recent changes to federal laws by removing restrictions on amounts subject to recovery by the Department of Health and Human Resources (DHHR). The bill redefines terms, including amending the definition of “third-party” to include any insurer that may be liable under an uninsured or underinsured motorist policy covering injuries to the recipient. The bill provides that the Department has a priority right to intervene and to be fully reimbursed for any payments made for past medical care before a recipient can recover any of their own costs for medical care from a third party. When determined to be cost effective, DHHR may negotiate for reduction in the lien amount to incentivize Medicaid members to pursue actions against liable third parties.

Within 30 days of receipt of the notice of a proposed settlement by a recipient, DHHR must notify the recipient of its consent or rejection of the proposed allocation. If the Department consents, the recipient or his or her legal representative must issue payment out of the settlement proceeds in a manner directed by the Secretary or his or her designee within 30 days of consent to the proposed allocation. If the Department rejects the proposed allocation, the recipient or legal representative must petition the court for a determination within 30 days regarding the appropriateness of the proposed settlement. The court must give due consideration to DHHR’s interests in being fairly reimbursed for purposes of the operation of the Medicaid program. The bill exempts a lien of less than \$1,500 from requirements of the article. The bill provides that a recipient that fails to notify DHHR of a settlement is liable for settlement amounts to which DHHR is entitled plus interest from date of settlement.

CODE REFERENCE: West Virginia Code §9-5-11 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Vetoed March 25, 2020

House Bill 4581

Relating to West Virginia Clearance for Access: Registry and Employment Screening

The bill includes employees of the Department of Health and Human Resources in the West Virginia Clearance for Access Registry and employment screening program. This will require the department to conduct criminal background checks on department employees or employees with direct access. Direct Access means physical contact with a resident, personally identifiable information, protected health information or financial information.

The bill revises the prescreening process by removing the language that permitted an individual to apply for a variance after the prescreening indicated a negative finding.

The bill reduces the time the Secretary has to respond to background checks from 90 days to 60 days.

CODE REFERENCE: West Virginia Code §16-49-1 through §16-49-8 – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 4, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4620

Redefining definition of "recovery residence"

The purpose of this bill is to clarify that the article does not permit a structure that would not normally be classified as a single-family dwelling (an apartment building) to be exempt from the state building code or fire code.

CODE REFERENCE: West Virginia Code §16-59-2 – amended

DATE OF PASSAGE: March 3, 2020

EFFECTIVE DATE: June 1, 2020

ACTION BY GOVERNOR: Signed March 25, 2020

House Bill 4777

Relating to the right of disposition of remains

The bill permits an adult grandchild to be added to the list of persons able to control disposition of the remains of a deceased person.

CODE REFERENCE: West Virginia Code §30-6-22a – amended

DATE OF PASSAGE: March 7, 2020

EFFECTIVE DATE: June 5, 2020

ACTION BY GOVERNOR: Signed March 24, 2020

2019 Regular Session



Senate Bill 60

Licensing practice of athletic training

This bill creates a license and scope of practice for athletic trainers and provides for criminal penalties. The bill has a new definition for the following the following main items:

- Athletic injury or condition which now means any injury or condition sustained by an individual that occurs during or as a result of the individual participation in organized athletic or recreational athletic activity that requires physical strength, agility, flexibility, speed, stamina, or range of motion or substantially similar injury or condition resulting from occupational activity immediately upon the onset of such injury or condition.
- General Supervision was amended to include supervision from many licensed practitioners, including a doctor of osteopathy, doctor of chiropractic, podiatrist, doctor of medicine, or physical therapist.
- The scope of practice of athletic training is defined as the application of principles, methods and procedures for managing athletic injuries or conditions, which shall include the prevention, emergency care, clinical examination and assessment, therapeutic intervention and treatment of athletic injuries or conditions through the use of appropriate preventative and supportive devices and within the professional preparation and education of a licensed athletic trainer.
 - Athletic training includes recognizing illness and referring to the appropriate medical professional and implementation of treatment pursuant to the orders of those professionals listed under General Supervisions within this article. It does not include the practice of physical therapy, the practice of occupational therapy, the practice of medicine, the practice of osteopathic medicine, surgery, the practice of chiropractic, the management of systemic medical or neurological conditions or diseases of body systems that are not within the professional preparation or education of a licensed athletic trainer.

The bill provides for the licensure process and payment of fees, a temporary permit process, renewal of licensure, a process for delinquent and expired licenses, inactive licenses, complaints, appeal and judicial review. A person violating this code is guilty to a misdemeanor and upon conviction shall be fined not less than \$100 nor more than \$5,000 or confined in jail not more than 6 months or both fined and confined. The final bill excludes definitions for BOC which was previously defined as National Athletic Trainers Board of Certification and CAATE which was defined as the Commission on Accreditation of Athletic Training. Finally, the bill provides nothing in the article may be construed to limit the use of the term athletic trainer in a secondary school setting by persons who were practicing athletic training under a West Virginia Education Athletic Certification in accordance with a policy in effect prior to July 1, 2011, provided that this policy only applies to persons practicing athletic training certified by the West Virginia Board of Education prior to July 1, 2011 and any additional persons practicing athletic training excluding these specified individuals shall meet the provisions of this article.

CODE REFERENCE: West Virginia Code §30-20A-1 through §30-20A-7 – amended; §30-20A-8 through §30-20A-16 – new

DATE OF PASSAGE: March 6, 2019

EFFECTIVE DATE: June 4, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 26, 2019

Senate Bill 175

Authorizing DHHR promulgate legislative rules

This bill contains nine Department of Health and Human Resources rules which constitute Bundle 5. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health and Human Resources, Collection and Exchange of Data Related to Overdoses, 69 CSR 14

This rule amends a current rule. This rule sets out the process for exchange of data from various entities with the Office of Drug Control Policy. The changes were made necessary by the passage of Senate Bill 272 during the 2018 Regular Session of the Legislature, which required the exchange of necessary data. The information will be uploaded to a database on fatal and non-fatal overdoses.

The substantive changes to the rule add hospital emergency rooms and departments to the list of mandatory reporters. Also, the reporting requirements were expanded to include reports on, not only suspected overdoses or reported overdoses, but also on confirmed overdoses.

The Senate Committee on Health and Human Resources amended the proposed rule by substituting a different definition for the term "Overdose."

Department of Health and Human Resources, Behavioral Health Centers Licensure, 64 CSR 11

This rule amends an existing rule. The purpose of the rule is to license and regulate behavioral health facilities. The last time this rule was amended was in 2000.

The rule lists a number of programs or services which are not subject to the provisions of the rule. Significant amendments have been made to the definition section. Among the notable changes was the combination of the various definitions of types of "abuse" into a single definition. Previous definitions included "physical", "psychological", and "verbal" abuse.

Section four of the rule pertains to the licensing procedure. This section has been substantially rewritten, however, the provisions are not substantially modified from existing provisions. The provisions of the section regarding "Issuance" have been divided into two separate sections providing detail on the types of licenses which may be issued. These provisions are fairly standard licensing provisions. Among them are an initial license – valid for a six-month period – a regular license – valid for up to two years – and a provisional license – valid for six months.

The rule addresses risk management. This section was previously known as "Health and Safety." It has been scaled back to require appropriate types of insurance regarding liability, fire, theft, and automobiles. It also requires employees who manage consumer funds be bonded. There are also specific safety requirements related to transportation for use with consumers. Finally, the newly rewritten section provides for quality assurance measures.

There is a newly entitled section which requires all providers meet all pertinent and applicable federal, state, and local laws, rules, and regulations, including all necessary licensing provisions. This section also includes provisions for security, retention, maintenance, and destruction of consumer records.

A new section regarding "Financial Management" has been created. It provides for a budget for the facility sufficient to meet the requirements for provider services, accounting for consumer funds, and adherence to all governmental requirements.

A second new section has been added regarding oversight and administration of staff. These provisions deal with training and orientation of staff, background checks, job descriptions, supervision of staff, volunteers and students, and employee record keeping requirements.

Most of the amendments to the rule occurred in the section now entitled "Services." This section requires providers to have written descriptions of the services they offer. There are specific requirements for admission, including assessment and intake procedures. There are also requirements for: planning of services which include an initial plan of service; an ongoing plan of care or treatment strategy; coordination of services, should the consumer need services beyond behavioral health services; reviews of the plan of service; treatment provisions for "critical treatment junctures;" discharge planning; services for special populations, if the provider offers such services; incidents of abuse and neglect; critical incidents; injuries of unknown source; management of inappropriate behavior, including behavior intervention; emergency planning for potentially dangerous behavior; medical and dental procedures for persons who are incapacitated or who have developmental disabilities; respite care; documentation standards for residential services; and standards for 24-hour medical monitoring.

The Senate made minor technical amendments. However, the House of Delegates amended the rule for the purposes of substance use disorder services. The amendment authorizes OFLAC, through reciprocity, to license an out-of-state provider, who is enrolled to accept West Virginia Medicaid and is authorized to provide behavioral health services in its state, as a West Virginia Behavioral Health Center under this rule.

Department of Health and Human Resources, Assisted Living Residences, 69 CSR 14

This rule is an amendment to an existing rule. The rule is being updated to reflect statutory changes made over time. The rule sets forth standards for licensing and operation of assisted living residences.

The provisions of the rule related to criminal background checks has been updated to reflect the current process for obtaining criminal background checks through the West Virginia Clearance for Access Registry System.

Section 5 of the rule pertaining to Resident Rights, specifically regarding legal representatives, was amended to reflect that a legal representative may only act within the confines of the authority he or she has been given and may not "over-reach." This section of the rule has also been updated to reflect advances in technology by granting residents the right to use computer and other electronic communications.

Several substantive changes were made to Section 6 relating to Health Care Standards. These changes include: deleting and rewriting ambiguous language regarding seeking behavioral health treatment when a risk persists; updating provisions for administration of drugs and eliminating unused drugs; eliminating ambiguous language regarding implementing registered nurse care; services and staff training; and adding specificity to who qualifies as a "next of kin."

Section 12, entitled Civil Penalties, License Restrictions, and Revocations has been deleted and broken down into four new sections dealing with licensing denials, revocations and suspensions, penalties and equitable relief, administrative due process, and administrative and judicial review. These sections contain the reasons, process, and procedure for acting upon a license issued to an assisted living residence. They also set out an informal dispute resolution process, grounds for denial, revocation, or suspension of a license and the effect of a denial, revocation, or suspension. Other sections provide the available penalties which may be levied, the equitable relief available, due process concerns and the process for appeals and judicial review.

The Senate made technical amendments to the rule on page 42, subdivision 11.8.1., by striking out the words “federal or state law or this rule” and inserting in lieu thereof the words “subdivision 11.8.2., of this rule.”

Department of Health and Human Resources, Newborn Screening System, 64 CSR 91

This rule amends a current rule. It sets forth the requirement for the Bureau for Public Health within the Department of Health and Human Resources to provide medical, dietary, and related assistance to children determined to be afflicted with a disease set out in code at W. Va. Code §16-22-3(a). These include:

- Phenylketonuria; Galactosemia; Hypothyroidism; Sickle cell anemia;
- Congenital adrenal hyperplasia; Cystic fibrosis;
- Biotinidase; and
- Other diseases specified by the bureau.

The diseases required to be tested for are set forth in the rule. These were originally set forth in W. Va. Code §64-91-4 with various dates of implementation for the required testing. All of the implementation dates have passed, and this section has now been repealed and the required tests are set forth in subsection 5.2 of the rule.

The previous rule sets out a fee schedule, including a cap of \$125.00 per newborn birthing screening kit after July 1, 2008. The current rule eliminates the fee and permits the Bureau for Public Health to charge a birthing facility or individual attending the birth for each newborn screen consistent with prevailing health insurance reimbursement rates for newborn screening.

The Senate Committee on Health and Human Resources adopted an amendment, which is contained in the Committee Substitute, requiring screening for the following diseases: Lysosomal Storage Disorders; X-Linked Adrenoleukodystrophy, X-ALD; and Spinal Muscular Atrophy (SMA).

Department of Health and Human Resources, Medication Assisted Treatment – Office-Based Medication-Assisted Treatment, 69 CSR 12

This rule amends a current rule to reflect the changes necessitated by the passage of Senate Bill No. 273 during the 2018 session of the Legislature. Those changes were made to decrease the regulatory burden the current rule places on practitioners and to allow for more latitude in the professional discretion of medical personnel.

The rule sets out the standards and operation for medication-assisted treatment at an office-based facility which would traditionally involve suboxone.

The rule reduces the required training for newly-employed counselors and other non-physician clinical staff from 20 hours to 12 hours and eliminates unnecessary training requirements. It removes over-specificity in the training requirements and job descriptions to allow facilities more flexibility. The training requirements are set by the various licensing boards of the medical professionals employed by the facility.

The amendment eliminates risk management requirements from the rule, allowing facilities to set individual policies applicable to the facility. The medication storage portion of the rule was updated to give more latitude in alternative treatments and patient interaction regarding medication. Additionally, other regulations regarding matters more applicable to the Board of Pharmacy were also eliminated.

The procedures for the required drug testing are set forth in the rule. These are required to be conducted monthly, which provides for less frequent, but random tests, after the initial test and with patient continued compliance.

The rule specifies how special populations are dealt with, including patients with alcohol and polysubstance abuse patients, behavioral health needs, HIV, patients with chronic pain, pregnant patients, and persons in the criminal justice system. Procedures relative to treatment of these types of populations are set forth in the rule.

The House of Delegates amended the rule to add language on page 39, by inserting a subsection, 22.9 to read as follows: “Each OBMAT program shall provide or make referrals for each patient to obtain contraceptive drugs, devices or procedures.”

Department of Health and Human Resources, Chronic Pain Management Clinic Licensure, 69 CSR 08

This rule amends a current rule, pertaining to licensing procedures and requirements for operation of a pain clinic in West Virginia. The Office of Health Facilities Licensure and Certification began the process of reviewing clinics in July of 2014.

The changes to the rule were made necessary by the passage of Senate Bill No. 273 during the 2018 session of the Legislature.

The rule makes two substantive changes. The first is required due to the passage of Senate Bill 273 last session. In that bill, the Legislature clarified that for purposes of defining an entity as a “pain clinic,” the threshold is that 50% or more of the patients treated are prescribed or dispensed Schedule II opioids or other Schedule II controlled substances. Prior language provided that the threshold was that 50% or more of the patients treated were prescribed or dispensed opioids, not the more addictive Schedule II opioids.

The second change updates the criminal background check to require that it be processed through the West Virginia Clearance for Access. This is the current process used by the Department to conduct all criminal background checks.

Health Care Authority, Cooperative Agreement Approval and Compliance, 65 CSR 6

This rule is new. It implements the provisions of the cooperative agreement approval and compliance requirements of W. Va. Code §16-29B-28.

The rule requires the Health Care Authority (HCA) to review cooperative agreements between qualified hospitals and other health care providers (including other hospitals) for the provision of health care services. The rule sets out procedures for review of the agreements and the standards of review. The rule requires an annual report containing the most recent quality metrics published by the Centers for Medicare and Medicaid Services selected by each hospital. The annual report shall be used by the HCA to perform active supervision.

If the performance scores are below the 50th percentile, a corrective action plan is required. The HCA may accept, modify, or reject the plan.

The HCA may issue rebates to health plans if services exceed the Consumer Price Index by two percent.

The rule also provides for investigation, penalties, and due process and adopts a \$75,000 application fee and a yearly supervision fee not to exceed \$75,000.

CODE REFERENCE: West Virginia Code §64-5-1 and §64-5-2 – amended

DATE OF PASSAGE: March 6, 2019

EFFECTIVE DATE: March 6, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

Senate Bill 199

Authorizing certain miscellaneous agencies and boards promulgate legislative rules

This bill is known as the Miscellaneous Rules bundle which authorizes and directs the promulgation of 31 rules and the repeal of one rule which constitute Bundle 9. Only the legislative rules directly relating to the health care industry are included in this summary.

West Virginia Board of Licensed Dietitians, Licensure and Renewal Requirements, 31 CSR 1

This rule amends a current legislative rule by reducing the reinstatement fee from \$125 to \$50 and by adding a paper license verification fee of \$10.

Board of Medicine, Licensing and Disciplinary Procedures: Physicians, Podiatric Physicians and Surgeons, 11 CSR 1A

This rule amends a current legislative rule to comply with Senate Bill 499 which passed during the 2018 Regular Session. It reduces the number of years of post-graduate medical training which an international medical school graduate must complete from three to two years and eliminates the requirement that the training must be in the United States or Canada.

The rule also clarifies which malpractice settlements and judgements must be reported to the Board of Medicine to align the Board's malpractice reporting standards with other reporting requirements for malpractice, including the National Practitioner Data Bank.

Board of Medicine, Permitting and Disciplinary Procedures: Educational Permits for Graduate Medical Interns, Residents and Fellow, 11 CSR 12

This rule is new. The rule implements the provisions of House Bill 4027 which passed during the 2018 Session and creates a permit to participate in graduate medical training such as internship, residency or fellowship training. The fee for a permit is \$100.

Board of Osteopathic Medicine, Licensing Procedures for Osteopathic Physician, 24 CSR 1

This rule amends a current legislative rule. It extends the Patient Injury Compensation Fee of \$125 from June 30, 2020, to December 31, 2021.

Board of Pharmacy, Licensure and Practice of Pharmacist Care, 15 CSR 1

This rule amends a current legislative rule. In reorganizing its rules, the Board has removed sections related to pharmacist licensure and pharmacy permits and moved them to 15 CSR 15 and 15 CSR 16.

Board of Pharmacy, Registration of Pharmacy Technicians, 15 CSR 7

This rule amends a current legislative rule in response to House Bill 4025 which passed during the 2018 Regular Session. It permits a pharmacy technician who is nationally certified as a pharmacy technician and has practiced in another jurisdiction for at least a year to be registered. It also exempts a sales clerk from licensure as a pharmacy technician.

The rule also modifies the hours and time frame of training necessary for a pharmacy technician trainee, which comports with standards recently promulgated by the national certification organization.

Board of Pharmacy, Regulations Governing Pharmacy Permits, 15 CSR 15

This rule is new. The rule contains the provisions, previously in section 14, Series 1, regulating pharmacy permits.

Board of Pharmacy, Regulations Governing Pharmacists, 15 CSR 16

This rule is new. The rule contains the provisions regulating pharmacists, previously in sections 5 and 6 from 15 CSR 1.

Board of Pharmacy, The Substitution of Biological Pharmaceuticals, 15 CSR 17

This rule is new. The rule allows a pharmacist to substitute a less expensive interchangeable biological product, as defined and set forth in federal law (42 U.S.C. § 262(k)(4)), for a biological product, unless the prescriber specifically prescribes a brand name pharmaceutical. The rule also sets out a requirement that the pharmacist place the prescriber on notice within five days of the dispensing of an interchangeable biological product. This notice must include the specific product dispensed. The notice may be sent electronically, or by other means. The rule also sets forth record-keeping requirements.

Board of Examiners for Registered Professional Nurses, Policies, Standards, and Criteria for the Evaluation, Approval and National Nursing Accreditation of Prelicensure Nursing Education Programs, 19 CSR 1

This rule amends a current legislative rule. It was modified to reflect changes in the law effected by the passage of House Bill 4156 during the 2018 Regular Session. That bill effectively removed responsibility for accreditation of registered professional nursing programs from the Board of Examiners. Instead, nursing programs that are nationally accredited are automatically Board-approved and exempt from the Board's approval rules, as long as accreditation is maintained. House Bill 4156 provided that all existing programs must achieve accreditation by July 1, 2022. The bill also stated that nursing programs commenced after July 1, 2018, have 5 years to obtain national accreditation, with the Board having approval authority over the program until the program is accredited. House Bill 4156 also affected the requirements for full and part-time nursing faculty members.

The modifications to the rule implement the provisions and intent of House Bill 4156. References to the Board's accreditation of nursing education programs are changed to the Board's approval of the programs throughout the rule. The definition of "Board approved" in Section 2.5 of the rule makes clear that all nationally accredited nursing programs are considered Board-approved and are exempt from rules related to Board approval.

In Section 6, the rule sets out the process for establishing a new nursing program that is consistent with House Bill 4156. The rule also provides for the continuing evaluation and approval of nursing programs in Section 7, and, consistent with House Bill 4156, ends those evaluations once the program receives national accreditation. In Section 11, the rule sets out standards for full and part-time faculty members that conform to the standards in House Bill 4156.

Sections 3, 4, and 5 of the rule are new and address the purposes for nursing program approval, nursing education standards, and required criteria for nursing education programs. The language in these sections reflects national model provisions. Section 13 adds provisions that allow a program to use simulation as a substitute for traditional clinical experiences for up to 50% of its clinical hours and sets forth standards related to simulation.

Board of Examiners for Registered Professional Nurses, Requirements for Registration and Licensure and Conduct Constituting Professional Misconduct, 19 CSR 3

This rule amends a current legislative rule. The Board added a criminal background check for endorsement applicants and removes unnecessary language concerning the Commission of Foreign

Nursing Schools. It allows the Board to consider licensure of any applicant on a case by case basis if the applicant's criminal history record reports criminal offenses.

Board of Examiners for Registered Professional Nurses, Advanced Practice Registered Nurse, 19 CSR 7

This rule amends a current legislative rule by adding a 10-year sunset date and makes other technical changes.

Board of Examiners for Registered Professional Nurses, Standards for Scope of Professional Nursing Practice, 19 CSR 10

This rule amends a current legislative rule. The changes are to update to reflect national model language. It sets out standards of practice within the areas of professional accountability (Section 2.1); scope of practice (Section 2.2); patient advocacy (Section 2.3); and the organization, management, and supervision of the practice of nursing (Section 2.4).

Board of Examiners for Registered Professional Nurses, Fees for Services Rendered by the Board and Supplemental Renewal Fee for the Center for Nursing, 19 CSR 12

This rule amends a current legislative rule, by removing outdated language on methods for paying fees and by removing outdated fees.

Board of Examiners for Registered Professional Nurses, Dialysis Technicians 19 CSR 13

This rule amends a current legislative rule. The changes are required by the passage of House Bill 4023 during the 2018 Regular Session. The rule permits a dialysis technician who is practicing on a temporary permit to renew the temporary permit one time for a period of 18 months. It also deletes the cumbersome reciprocity process and adds a criminal background check requirement.

Board of Social Work Examiners, Qualifications for the Profession of Social Work 25 CSR 1

This rule amends a current legislative rule. The rule modifies the training, registration, and application requirements for clinical supervisors of individuals seeking to become Licensed Independent Clinical Social Workers. The rule also expands the permissible use of HIPPA compliant technology to meet the supervision requirements.

Board of Social Work Examiners, Code of Ethics 25 CSR 7

This rule amends a current legislative rule. The rule updates the reference to the Code of Ethics to the most recently adopted code by the National Association of Social Workers

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: March 8, 2019

ACTION BY GOVERNOR: March 22, 2019

Senate Bill 310

Establishing certain requirements for dental insurance

The bill pertains to agreements between dentists and insurance providers. The bill contains definitions. It provides a layer of protection for dentists by not allowing a third-party administrator from dictating to a provider fees on services which they do not cover. The language in the bill states that:

- A contract may not require approval of a fee by the network unless they are covered services pursuant to the underlying contract;
- Dentists are to charge their customary fee for services and cannot be required by a plan to charge more for uncovered services; and,
- Requires reasonable reimbursement to a provider by a plan thereby precluding a plan from providing nominal services simply to claim the services are covered services.

Finally, the bill has an internal effective date of July 1, 2019.

The language in the bill is model language adopted by the National Council of Insurance Legislators in 2010. 38 of 50 states have adopted similar language.

CODE REFERENCE: West Virginia Code §33-6-39 – new

DATE OF PASSAGE: March 4, 2019

EFFECTIVE DATE: July 1, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 318

Transferring Medicaid Fraud Control Unit to Attorney General's office

This bill transfers the Medicaid Fraud Control Unit from the Department of Health and Human Resources (DHHR) to the Office of the Attorney General and continues its operation in the Office of the Attorney General after October 1, 2019. All employees of the Medicaid Fraud Control Unit will be transferred and become employees of the Office of the Attorney General at their existing hourly rate or salary and with all accrued benefits. The Medicaid Fraud Control Unit's authorities, powers, and duties will remain unchanged by the transfer.

The bill provides that on or before December 31, 2022, the Legislative Auditor shall study and report to the Joint Committee on Government and Finance regarding the performance of the Medicaid Fraud Control Unit within the Office of the Attorney General during the previous three years in comparison to the performance of the unit while it operated within DHHR. The bill provides that after the effective date the Secretary and DHHR must fully cooperate with the Office of the Attorney General on any investigation, prosecution, or civil action and that the Secretary must promptly provide the Attorney General with any information or document requests. If the Attorney General declines to prosecute a civil action brought by the Medicaid Fraud Control Unit, the civil action shall be maintained either by a prosecuting attorney or by any attorney in contract with or employed by DHHR. Section 9-7-6a limits the liability of DHHR, the Office of the Attorney General, or any of their employees or agents for any action taken under this article so long as it was taken in good faith.

CODE REFERENCE: West Virginia Code §9-7-1, §9-7-3, §9-7-6, and §9-7-6a – amended

DATE OF PASSAGE: March 7, 2019

EFFECTIVE DATE: October 1, 2019

ACTION BY GOVERNOR: March 25, 2019

Senate Bill 340

Repealing obsolete provisions of code relating to WV Physicians Mutual Insurance Company.

This bill repeals Article 20F of the insurance code, which created the Physicians' Mutual Insurance Company Act. The purpose of Article 20F, originally enacted in 2001 and subsequently amended, was to create a mechanism for the formation of a physicians' mutual insurance company that would provide a means for physicians to obtain medical liability insurance that is affordable, while also compensating persons who suffer injuries as a result of medical professional liability. The Board of Risk and Insurance Management (BRIM) was tasked with implementing the initial formation and organization of the company. The article creates a special revenue account, specifies that the company is to have a board of directors of certain members, and provides for the transfer of policies from BRIM to the company.

CODE REFERENCE: West Virginia Code §33-20F-1 et seq. – repealed

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed March 22, 2019

Senate Bill 400

Allowing Board of Dentistry create specialty licenses

The purpose of the bill is to permit the WV Board of Dentistry to create specialty licenses. The bill creates new definitions related to the specialty definitions including the following:

“Endodontics” is the branch of dentistry which is concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues. Its study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated periradicular conditions.

“Oral pathology” is the specialty of dentistry and discipline of pathology that deals with the nature, identification, and management of diseases affecting the oral and maxillofacial regions. It is a science that investigates the causes, processes, and effects of these diseases. The practice of oral pathology includes research and diagnosis of diseases using clinical, radiographic, microscopic, biochemical, or other examinations.

“Oral and maxillofacial radiology” is the specialty of dentistry and discipline of radiology concerned with the production and interpretation of images and data produced by all modalities of radiant energy that are used for the diagnosis and management of diseases, disorders and conditions of the oral and maxillofacial region.

“Oral and maxillofacial surgery” is the specialty of dentistry which includes the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

“Orthodontics and dentofacial orthopedics” is the dental specialty that includes the diagnosis, prevention, interception, and correction of malocclusion, as well as neuromuscular and skeletal abnormalities of the developing or mature orofacial structures.

“Pediatric Dentistry” is an age-defined specialty that provides both primary and comprehensive preventive and therapeutic oral health care for infants and children through adolescence, including those with special health care needs.

“Periodontics” is that specialty of dentistry which encompasses the prevention, diagnosis and treatment of diseases of the supporting and surrounding tissues of the teeth or their substitutes and the maintenance of the health, function and esthetics of these structures and tissues.

“Prosthodontics” is the dental specialty pertaining to the diagnosis, treatment planning, rehabilitation and maintenance of the oral function, comfort, appearance and health of patients with clinical conditions associated with missing or deficient teeth and/or oral and maxillofacial tissues using biocompatible substitutes.

In order to be granted a license to practice dentistry by the Board, an applicant must meet several criteria. The fourth criteria has been edited to read:

§30-4-8(a)

(4) Has successfully passed a National Board examination as given by the Joint Commission on National Dental Examinations and a clinical examination administered by one or more of the following Commission on Dental Competency Assessments, Central Regional Dental Testing Service, Council of Interstate Testing Agencies, Southern Regional Testing Agency, Western Regional Examining Board, or successor agency, which demonstrates competency and passes each individual component with no compensatory scoring in;

(A) Endodontics, including access opening of a posterior tooth and access, canal instrumentation and obturation of an anterior tooth;

(B) Fixed Prosthodontics, including an anterior crown preparation and two posterior crown preparations involving a fixed partial denture factor;

(C) Periodontics, including scaling and root planning in a patient based clinical setting; and

(D) Restorative, including a class II amalgam or composite preparation and restoration and a class III composite preparation and restoration in a patient based clinical setting; and

(E) The board may consider clinical examinations taken prior to July 1, 2019, or individual state clinical examinations as equivalent which demonstrates competency.

The bill provides that the board may issue specialty licenses authorizing a dentist to represent himself or herself as a specialist in the following circumstances:

§30-4-8a

(b) A dentist may not represent himself or herself to the public as a specialist, nor practice as a specialist, unless the individual:

(1) Has successfully completed a board recognized dental specialty/advanced education program accredited by the Commission on Dental Accreditation;

(2) Holds a general dental license in this state; and

(3) Has completed any additional requirements set forth in state law or rules and has been issued a dental specialty license by the board.

The following specialties are recognized:

(1) Dental public health. The licensee shall have successfully completed a minimum of one full-time academic year of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(2) Endodontics. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(3) Oral and maxillofacial surgery. Licensee shall have successfully completed a minimum of three full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(4) Oral and maxillofacial radiology. The licensee shall have successfully completed a minimum of two full-time years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(5) Orthodontics and dentofacial orthopedics. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency. In addition, any applicant for an orthodontic and dentofacial orthopedic specialty certificate commencing on July 1, 2019, shall submit verification of successful completion of the American Board of Orthodontics written examination.

(6) Pediatric dentistry. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(7) Periodontics. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(8) Prosthodontics. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

(9) Oral pathology. The licensee shall have successfully completed a minimum of two full-time academic years of at least eight calendar months each of graduate or post-graduate education, internship or residency.

The licensee shall limit his or her practice of dentistry only to the specialty in which he or she is licensed and in which he or she holds himself or herself out to the public as a specialist.

The licensee shall limit his or her listing in the telephone directory to the specialties in which he or she has an office or offices.

The limitation of practice is removed for purposes of volunteering services in organized health clinics and at charitable events.

License to practice dental hygiene

Among other criteria, satisfactorily passing a board approved patient-based exam designed to determine the applicant's level of clinical skills and is a graduate with a degree in dental hygiene from an approved dental hygiene program of a college, school, or dental department of a university.

CODE REFERENCE: West Virginia Code §30-4-3, §30-4-8, and §30-4-10 – amended; §30-4-8a – new

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed March 22, 2019

Senate Bill 489

Relating to Pharmacy Audit Integrity Act

The purpose of this bill is to provide for licensure of pharmacy benefit managers (PBM) with the Insurance Commissioner, set forth minimum reimbursement rates, and require PBMs to report data to PEIA. A pharmacy benefits manager is pharmacy benefits management for a covered entity. This is the procurement of prescription drugs at a negotiated contracted rate for dispensation within WV to covered individuals and the administration or management of prescription drug benefits by a covered entity for the benefit of covered individuals.

The bill adds the following new definitions:

- “340B Pharmacy” means an entity participating in the 340B drug program as outlined in 42 U.S.C. 256b including its pharmacy or contracted pharmacy;
- “Affiliate” means a pharmacy, pharmacist or technician that directly or indirectly through one or more intermediaries, owns or controls, is owned or controlled by or is under common ownership with a pharmacy benefit manager; and
- “Third-party” means an insurer, health benefit plan for employees which provides a pharmacy benefit plan, a participating public agency which provides a system of health insurance for public employees, their dependents and retirees, or any other insurer or organization that provides health coverage or benefits or coverage of prescriptions drugs as part of workers compensation insurance in accordance with state or federal law. The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

This bill provides specific criteria for an auditing entity to follow to determine when a charge-back or recoupment involving a dispensed product is appropriate. Specifically, fraud or other intentional and willful misrepresentation as evidenced by a review of the claims data, statements, physical review, or other investigative methods; dispensing in excess of the benefit design, as established by the plan sponsor; prescriptions not filled in accordance with the prescriber’s order; or actual overpayment to the pharmacy.

This bill requires a pharmacy benefit manager to be licensed in the state of West Virginia. One may not establish or operate as a pharmacy benefits manager without first obtaining a license. The pharmacy benefits manager must provide typical license information including name, address, contact information of applicant, FEIN and any other information that the Insurance Commission may require. The term is two years from the date of issuance. The Insurance Commissioner shall determine the fee, single fee shall not exceed \$10,000. They shall demonstrate financial responsibility of \$1,000,000 in each application for license. The Insurance Commission shall propose legislative rules establishing licensing fees, application and financial standards and reporting requirements. An applicant must demonstrate network adequacy including that a PBM network shall not be mail order only but must have a mix of mail order and physical stores. The PBM shall provide a report describing the mix of mail order to physical stores in a place and time required by the Ins. Commissioner. Failure to timely provide the report may result in suspension or revocation of the PBM’s license. The Insurance Commissioner shall have enforcement powers over this section and may examine or audit the books and records of a pharmacy benefit manager provided that any information is proprietary and confidential and exempt from FOIA. There is no Fiduciary Obligation on behalf of the PBM.

This bill prohibits a pharmacy benefit manager from engaging in specified reimbursement practices with respect to 340B pharmacies. A pharmacy benefit manager, or any other third party, that reimburses

a 340B Entity for drugs that are subject to an agreement under 42 U.S.C. §256b shall not reimburse the 340B Entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B Entities, and shall not assess any fee, chargeback, or other adjustment upon the 340B Entity on the basis that the 340B Entity participates in the program set forth in 42 U.S.C. §256b.

This bill removed provisions relating to establishing minimum reimbursement rates for pharmacies and pharmacists that were contained in earlier draft revisions.

This bill requires PEIA to include information in contracts related to pharmacy benefit managers. All contracts must have quarterly reporting to PEIA for all pharmacy claims identifying the amount paid to the pharmacy provider per claim, including but not limited to the cost of the drug reimbursed, dispensing fees, Copayments and the amount charged to the agency for each claim by the PBM.

In the event that there is a difference between these amounts for any claim, the pharmacy benefit manager shall report an itemization of all administrative fees, rebates, or processing charges associated with the claim. All data shall be kept secure, shall be maintained as confidential, and shall not be disclosed outside the agency and is exempt from FOIA. Aggregate non-proprietary data shall be reported at least quarterly to the Joint Committee on Government and Finance on the implementation of this subsection and its impact on program expenditures, including any difference or spread between the amount paid the pharmacy benefit managers to the pharmacy providers and the amount charged to the agency for each claim by the pharmacy benefit manager. If the information is not provided the agency may terminate the contract and the office of the Insurance Commissioner shall discipline the pharmacy benefits manager as provided in §33-51-8(e) of this code.

CODE REFERENCE: §5-16-9, 33-51-3, 33-51-4, 33-51-7, 33-51-8, and 31-51-9 – amended; §33-51-10 – new

DATE OF PASSAGE: February 26, 2019

EFFECTIVE DATE: February 26, 2019

ACTION BY GOVERNOR: Signed March 1, 2019

Senate Bill 510

Relating to medical professional liability

This bill amends the prerequisites for filing a medical professional liability claim. Prior to filing a medical professional liability claim in West Virginia, a 30-day notice is required to be signed by a health care provider qualified as an expert under the West Virginia Rules of Evidence. This is known as a certificate of merit. The bill also makes a number of changes to that process, including:

- It requires that the 30-day notice for filing a claim include specified information about any agents, servants, employees, or officers of the health care provider who is to be named in the potential suit if the suit is premised on the act or failure to act of the agents, servants, employees, or officers of the health care provider.
- It requires that a health care provider who signs a certificate of merit is qualified as an expert under the West Virginia Rules of Evidence, meets the requirements of W. Va. Code §55-7B-7(a)(5) and W. Va. Code §55-7B-7(a)(6), and devotes, at the time of medical injury, 60 percent of his or her professional time annually to the active clinical practice in his or her medical field or specialty, or to teaching in his or her medical field or specialty in an accredited university.
- If the health care provider who signs the certificate of merit meets the above qualifications, it establishes a presumption that the health care provider is qualified as an expert for the purposes of executing a certificate of merit.
- It updates the requirements for what a certificate of merit shall state with particularity and include, specifically that a list of all medical records and other information reviewed by the expert executing the certificate of merit be included.
- It provides that no challenge to the notice of claim may be raised prior to receipt of the notice of claim and the executed screening certificate of merit.

CODE REFERENCE: West Virginia Code §55-7B-6 – amended

DATE OF PASSAGE: February 28, 2019

EFFECTIVE DATE: May 29, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 518

Restricting sale and trade of dextromethorphan

This bill prohibits a person from knowingly and willfully selling a finished drug product containing dextromethorphan (DXM) to a person under 18 years of age. DXM is most commonly used to relieve coughs due to colds or influenza. This bill requires proof of age from any individual presumed to be less than 25 years of age prior to purchasing a finished drug product with any quantity of DXM unless from the purchaser's outward appearance the person making the sale would reasonably presume the purchaser to be at least 25 years of age. This section does not apply to medication containing DXM sold pursuant to a prescription. A person that violates the act is guilty of a misdemeanor and shall be fined not less than \$100.00 nor more than \$250.00.

CODE REFERENCE: West Virginia Code §60A-4-417 – new

DATE OF PASSAGE: March 2, 2019

EFFECTIVE DATE: May 31, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 22, 2019

Senate Bill 519

Requiring county emergency dispatchers complete course for telephonic cardiopulmonary resuscitation

This bill was introduced at the request of the American Heart Association. The purpose of the bill is to add an additional training requirement to dispatchers at county emergency call centers. The training would focus on providing telephonic cardiopulmonary resuscitation compression only services in an out of hospital setting. The training is required to be nationally recognized and would be selected by the Medical Director of dispatch center.

The bill sets out that the required training would become effective 7/1/2020 and would require all persons hired after 7/1/2019 to complete the training within one year of the date of employment.

CODE REFERENCE: West Virginia Code §24-6-5 – amended

DATE OF PASSAGE: March 5, 2019

EFFECTIVE DATE: June 3, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 26, 2019

Senate Bill 520

Requiring entities report drug overdoses

The purpose of the bill is to permit the Office of Drug Control Policy to adopt a specific information technology reporting platform for overdose reporting and to set shorter time limits for mandatory reporters. Specifically, the bill requires all mandatory reporters to submit their report within 72 hours after the provider responds to the incident and via an appropriate information technology platform. Current law requires quarterly reporting.

The bill deletes mandatory reporters from a list of reporters required to submit a report including, pharmacies operating in the state, prosecuting attorneys and departments of hospitals. Hospital emergency rooms are still listed as mandatory reporters.

The bill defines the following terms:

- “Information technology platform” is the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping Application Program or other program designated by DHHR in legislative rule.
- “Overdose” is defined consistent with DHHR’s ODCP rule.
- “Opioid antagonist” is a federal FDA approved drug for the treatment of an opiate-related overdose, such as naloxone hydrochloride or other substance that, when administered, negates or neutralizes, in whole or in part, the pharmacological effects of an opioid in the body.

CODE REFERENCE: West Virginia Code §16-5T-3 and §16-5T-4 – amended

DATE OF PASSAGE: March 5, 2019

EFFECTIVE DATE: June 3, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 537

Creating workgroup to review hospice need standards

The bill directs the WV Health Care Authority to form a working group to review hospice services in West Virginia. The bill directs that a workgroup be formed and names members of the group. The bill specifies the duties of the workgroup as: establishing a model for data collection to best predict future need of hospice service in West Virginia and collect the necessary data; review the access to hospice service in West Virginia as well as future needs; examine how West Virginia serves its population with hospice services; examine the financial condition of the current delivery system; recommend a need methodology to the Authority for the development of new hospice service; and make other recommendations the work group deems appropriate.

The Authority is required to provide staff for the workgroup and schedule public hearings in each congressional district in West Virginia as it relates to the provision of hospice services in the state. The work group shall approve the final report by September 30, 2019 and a copy shall be submitted to the Joint Committee on Government and Finance. The work group will sunset on December 31, 2019.

The bill provides that the Authority shall consider modifying the hospice standards based on the report's findings no later than December 1, 2019. Prior to approving the standards, the Authority shall submit the standards to LOCHHRA who shall have 30 days to review the standards and provide input prior to submission to the Governor for approval. The bill provides that the need standards regulating hospice and home health in effect on January 1, 2018 shall remain in effect until the Governor approves a standard developed according to this section. Any hospice standards drafted or in any way modified pursuant to this section shall not become effective until December 31, 2019.

CODE REFERENCE: West Virginia Code §16-29B-31 – new

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 27, 2019

Senate Bill 545

Relating to HIV testing

The bill amends the existing legislative rule (114 CSR 27) relating to AIDS-related underwriting questions and AIDS testing in connection with applications for life or health insurance policies. The amendment strikes language designating specific tests that are acceptable under the existing rule and provides that if any confirmatory test produces a negative result, the testing ceases and the proposed insured cannot be denied coverage based on AIDS-related testing.

CODE REFERENCE: West Virginia Code §64-7-4 – amended

DATE OF PASSAGE: March 2, 2019

EFFECTIVE DATE: March 2, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 26, 2019

Senate Bill 546

Creating tax on certain acute care hospitals

This bill imposes a tax increase on specified acute care hospitals to maximize federal funding in order to increase practitioner payment for employed practitioners. The bill applies to providers of inpatient and outpatient hospital services. This bill imposes an additional tax of 0.13 percent on the gross receipts received or receivable by eligible acute care hospitals that provide inpatient and outpatient hospital services in the state.

The bill excludes:

- A state owned or designed facility
- A critical access hospital
- A licensed long-term acute care hospital
- A licensed freestanding psychiatric or medical rehab hospital

The term practitioner means a physician licensed pursuant to the provisions of §30-3-1 and §30-14-1 of this code.

The tax may not be collected until each of the following:

- WV BMS incorporates the payment methodology into the appropriate contracts and agreements;
- The WVBMS receives the necessary approvals from CMS.

The creation of the fund:

- All fees shall be deposited into a special fund known as the “Acute Care Clearing Fund”. The amount of tax collected, including any interest, additions to the tax, less the amount of allowable refunds, and costs of collections shall be deposited into this fund. Disbursements may only be used to support increasing practitioner payment fee schedules for practitioners employed by eligible acute care hospitals.

The collection of the tax shall be suspended on any of the following:

- The effective date of any action by Congress that would disqualify the taxes imposed by this section from counting toward state Medicaid funds to be used to determine federal participation;
- The effective date of any decision or other determination by the Legislation, court, or other body that disqualifies the tax from counting toward state Medicaid funds to be used to determine federal participation; and
- If the funds are not used to effectuate the provisions of this section.

If the fund is suspended, then the funds are transferred to the Medical services fund and subject to the discretion of BMS.

The provisions apply on or after July 1, 2019. The section expires on or after June 30, 2021.

CODE REFERENCE: West Virginia Code §11-27-39 – new

DATE OF PASSAGE: March 7, 2019

EFFECTIVE DATE: July 1, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 564

Expanding comprehensive coverage for pregnant women through Medicaid

The bill makes findings that public and private insurance mechanisms remain inadequate for middle income women and children who are among the most likely to be without insurance. The bill provides that DHHR shall extend Medicaid coverage to pregnant women and their newborns to 185 percent of the federal poverty level effective July 1, 2019 or as soon as possible and provide 60 days postpartum care. This is an increase from 150 percent of the federal poverty level.

The Children's Health Insurance Board shall create a benefit plan for comprehensive coverage for pregnant women between 185 percent and 300 percent of the federal poverty level including prenatal care, delivery and 60 days postpartum care authorized under the Children's Health Insurance Program as funding is available.

CODE REFERENCE: West Virginia Code §5-16B-6d and §9-5-12 – amended

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed by the Governor on March 25, 2019

Senate Bill 593

Permitting critical access hospital become community outpatient medical center

The bill permits a critical access hospital located in an urban area (metropolitan statistical area (MSA) county) to convert to a community outpatient medical center if (1) it has been designated as a critical access hospital for at least one year, and (2) it is designated as a critical access hospital at the time of the application to convert to a community outpatient medical center.

Once converted, the community outpatient medical center shall provide emergency medical care and observation 24 hours a day, 7 days a week, treat all patients regardless of insurance status and have transfer protocols.

The bill permits DHHR to develop a legislative rule to implement these provisions.

CODE REFERENCE: West Virginia Code §16-5B-14 – amended

DATE OF PASSAGE: March 1, 2019

EFFECTIVE DATE: May 30, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 640

Regulating sudden cardiac arrest prevention

The bill establishes the Sudden Cardiac Arrest Prevention Act. The purpose of the proposed Act is to promote education of sudden cardiac arrest to aid in detection and prevention.

The bill defines athletic activity as interscholastic athletics, and athletic contests or competitions sponsored by or associated with a school entity, including practices. The bill defines a school as any school under the jurisdiction of a county board of education.

The bill provides that the Department of Education working in conjunction with the State Health Officer will develop educational materials and guidelines, including a warning sign information sheet, regarding sudden cardiac arrest for students of all ages and risks associated with continuing to play or practice after experiencing fainting or seizures during exercise, unexplained shortness of breath, chest pains, racing heart, or extreme fatigue.

The bill provides that the educational materials will be posted on the relevant organization's web pages.

Prior to starting each athletic season, a school that is subject to this section shall hold an informational meeting for students regarding the warning signs of sudden cardiac arrest. Additionally, in order to participate in an athletic activity, the student must sign a waiver acknowledging that the student has received a copy of information of the DHHR and BOE web pages.

The bill provides that no individual may coach an athletic activity until the individual has completed the cardiac arrest training course. This training is required annually.

The bill provides that a student shall not be allowed to participate in an athletic activity if the student is known to have exhibited syncope or fainting and has not been cleared to return to practice or the student experiences syncope or fainting while participating in or immediately following an athletic activity.

If a student is not allowed to participate or removed the student shall be cleared, in writing, to return to play by specified medical professionals.

The governing body of the school can determine penalties for a coach found in violation of this section.

The bill provides protection from liability for a school board, member of a school district, school employee, including a coach is not liable in damages for providing services or performing duties in this bill.

CODE REFERENCE: West Virginia Code §16-56-1 through §16-56-4

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 641

Relating to Primary Care Support Program

The purpose of this bill is to convert the existing revolving loan fund to a grant program for federally qualified health centers (FQHC) and federally qualified look-alike in order to secure federal medical assistance percentage (FMAP) funding.

The bill provides that FQHC look-alikes already receiving funding at the time this program is created shall continue to receive funding annually. Upon approval the DHHR Secretary, FHQCs in need of immediate financial assistance may be granted funding annually. All funds designated to federally designated qualified health centers may be transferred to Medicaid for the purpose of securing federal funding.

The primary care support program shall conduct and make available upon request an annual report which shall consist of the WV Medicaid primary care expenditures as a percentage of total WV Medicaid expenditures. The bill additionally provides that the Secretary may use certain portions of funds within this account for activities in support of rural and primary care.

CODE REFERENCE: West Virginia Code §16-2H-3 and §16-2H-4 – repealed; §16-2H-2 – amended

DATE OF PASSAGE: March 4, 2019

EFFECTIVE DATE: March 4, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 653

Relating generally to practice of medical corporations

The bill concerns the practice of medical corporations. Under current law, a medical corporation may only be comprised of individual physicians licensed to practice medicine and surgery in this state pursuant to W.Va. Code §30-3-15. The bill permits podiatric physicians and physician assistants to become shareholders in a medical corporation along with physicians. This change is reflected throughout the document. Additionally, the bill replaces references to the practice of podiatry with podiatric practice.

The bill provides that hospitals licensed pursuant to W.Va. Code §16-5B-1 are not required to obtain a certificate of authorization so long as the hospital does not exercise control of the independent medical judgment of physicians and podiatric physicians.

Additionally, the bill provides that physician assistants can become shareholders in a medical corporation with physician's subject to W.Va. Code §30-14-9a. This provides parity between allopathic physician's medical corporations and osteopathic medical corporations.

CODE REFERENCE: West Virginia Code §30-3-15 and §30-14-9a – amended

DATE OF PASSAGE: March 7, 2019

EFFECTIVE DATE: June 5, 2019

ACTION BY GOVERNOR: Signed March 25, 2019

Senate Bill 668

Relating to physician assistants collaborating with physicians in hospitals

The purpose of this bill is to provide requirements for physician assistants who are collaborating with physicians in hospitals under a newly created practice notification in a hospital setting. Currently, a physician assistant must practice pursuant to a practice agreement.

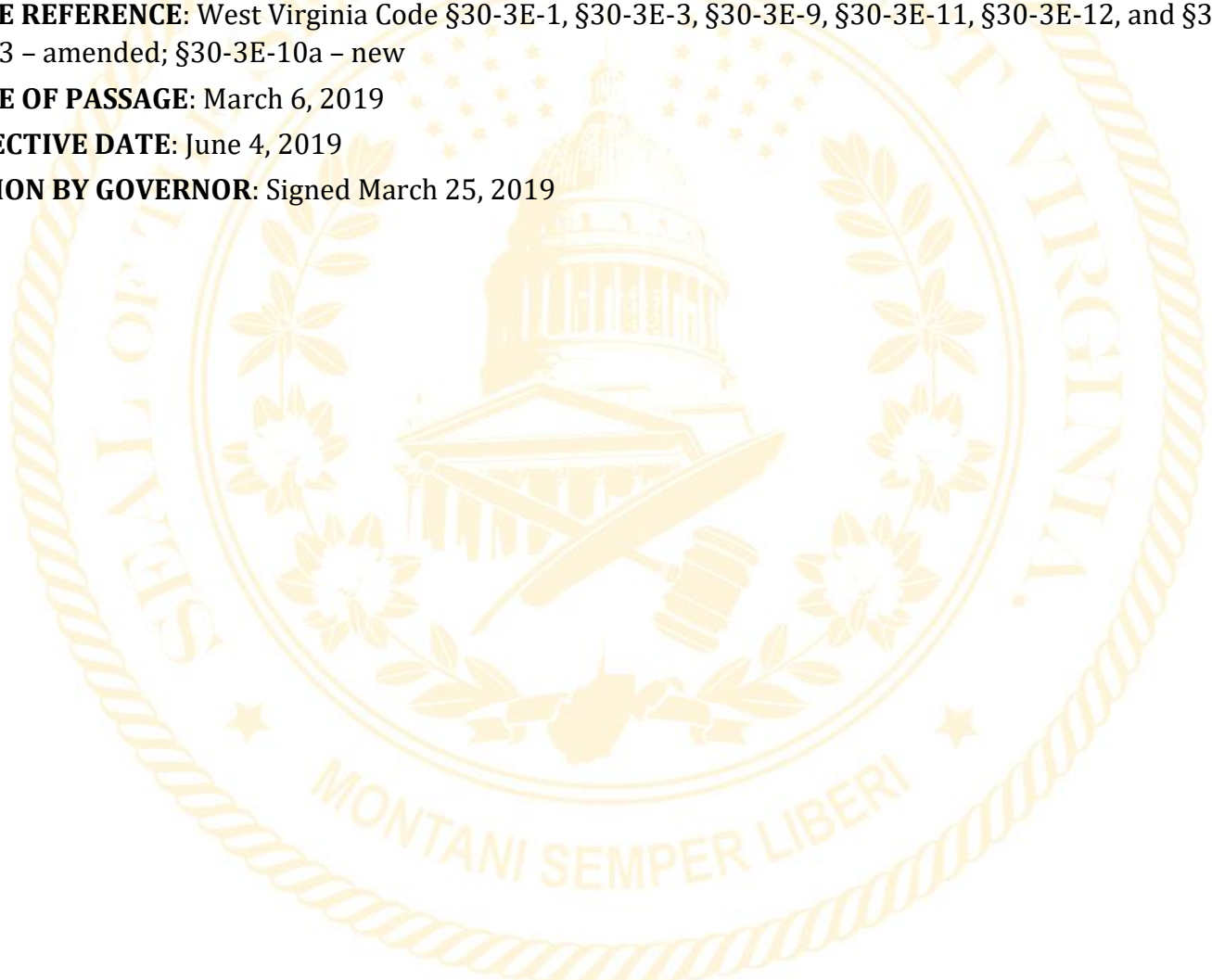
The bill has a definition for practice notification which means a written notice to the appropriate licensing board that a physician assistant will practice in collaboration with one or more physicians in a hospital in the State of West Virginia. The bill permits emergency rulemaking by the WV Board of Medicine. The bill provides that a physician assistant shall notify the board, in writing, within ten days of the termination of the practice notification. Failure to provide timely notification of termination constitutes unprofessional conduct and disciplinary proceedings may be instituted.

CODE REFERENCE: West Virginia Code §30-3E-1, §30-3E-3, §30-3E-9, §30-3E-11, §30-3E-12, and §30-3E-13 – amended; §30-3E-10a – new

DATE OF PASSAGE: March 6, 2019

EFFECTIVE DATE: June 4, 2019

ACTION BY GOVERNOR: Signed March 25, 2019



House Bill 2010

Relating to foster care

This bill updates the regulation of foster care. The foster care system has approximately 6,400 children with that population increasing significantly in the last 2 years.

This bill does nine things:

- **Mandates the transition of the foster care population into managed care;**
 - The bill requires that the DHHR transition the foster care system into a managed care system by January 1, 2020. A bill to do this was introduced in the House (HB4241) to transition foster children to managed care but it did not make it out of the House.
 - This transition would require payments for eligible services including home and community-based services to be made using a managed care model.
 - The secretary shall submit, if necessary, applications to the United States Department of Health and Human Services for waivers of federal Medicaid requirements that would otherwise be violated in the implementation of this program and shall consolidate any additional waivers where appropriate, Provided that this subsection does not apply to the Aged and Disabled Waiver, the Intellectual/Developmental Disabilities Waiver, and the Traumatic Brain Injury Waiver.
 - In designing the program, DHHR shall ensure:
 - Reduces fragmentation and offers a seamless approach to meeting needs
 - Delivers needed supports and services in the most integrated, appropriate, and cost-effective way possible;
 - Offers a continuum of acute care services, which includes an array of home and community-based options;
 - Includes a comprehensive quality approach across the entire continuum of care services; and
 - Consults with stakeholders in the program development process, and the managed care organization that is awarded the contract shall create a voluntary advisory group of foster parents, adoptive and kinship parents which shall meet every quarter for the first year following the effective date of the changes made to this section during the 2019 Regular session and then every six months thereafter to discuss issues they are encountering with the managed care organization and recommend solutions. The managed care organization shall report on the recommendations of the advisory group and address how and why procedures have or have not changed based upon those recommendations. This report shall be submitted to the Secretary and the Legislative Oversight Commission on Health and Human Resources Accountability as set forth in §16-29E-1 et seq. of this code and the public in a timely fashion and shall be available on the managed care organization's webpage.
 - The department shall evaluate the transition to managed care and shall collect and annually report on the following items: the number of claims submitted, the number of claims approved, the number of claims denied, the number of claims appealed, the resolution of appealed claims, the average time of an appeal, the average length of stay in a child residential care center, and health outcomes. The initial report shall be filed by July 1, 2021,

with the Legislative Oversight Commission on Health and Human Resources Accountability and the Foster Care Ombudsman with a final report submitted July 1, 2023.

- The transition to foster care shall terminate on June 30, 2024 unless cancelled at earlier
- The bill provides that an employee of the department who as a function of that employment has engaged in the development of any contract developed pursuant to the requirements of this section may not for a two-year period be employed by any or agency or company that has benefitted or stands to benefit directly or indirectly from a contract between the department that agency or company.
- The bill provides that any managed care company selected as the managed care contractor shall have at least 80 percent of the total full-time equivalent positions allocated to manage care of foster children in West Virginia according to the contract must have a primary work place in the state of West Virginia.
- **Creates a foster care child and parent ombudsman;**
 - The bill provides for the creation of a foster care ombudsman, with experience as a former foster parent or experience in the area of child welfare, whose job it is to advocate for foster children and foster parents, participate in any procedure to investigate and resolve complaints filed on behalf of the foster child, monitor development of federal and state legislation with respect to foster care services, establishing and maintaining a statewide uniform reporting system to collect data relating to complaints. The ombudsman shall participate in on-going training.
- **Implements performance-based contracting;**
 - The bill requires DHHR to enter into performance-based contracts with child placing agencies no later than December 1, 2020. DHHR will be required to annually evaluate its child placing agencies based upon certain negotiated contractual factors. Those factors include safety outcomes, permanency outcomes, well-being outcomes, incentives earned, and recruitment and retention of foster parents. The implementation dates are July 1, 2020 to issue the RFP, notify successful bidders September 1, 2020.
- **Studies kinship care;**
 - The bill requires DHHR to conduct a study and make recommendations for improving services provided to kinship foster families. This shall include at a minimum: (1) a review of the best practices in other states; (2) a proposal for an alternative system of regulation for kinship foster care that includes the same reimbursement as other foster care families as well as a reasonable time for obtaining certification; (3) an evaluation of what training and supports are needed to ensure that kinship care homes are successful; the results shall be shared by October 1, 2019
- **Requires DHHR to review and update their legislative rule to a reasonably prudent parent standard and to ensure normalcy for the foster child;**
 - The bill extends the time a foster family is certified from one year to three years, unless a substantial change occurs. A new criminal background check will occur at the time of recertification process. A home safety assessment is performed at least annually. DHHR has the sole authority to determine if a substantial change has occurred.
 - The bill provides that the rules may not prevent the placement or cause the removal of a foster child for cosmetic damage to a home. The bill provides that the rule shall permit the use of dedicated sleeping spaces as appropriate for the child's needs, age, and similar to other

household members. The bill provides rules shall be updated while considering normalcy and the reasonable and prudent parent standard. The rule must be revised and submitted for rulemaking by October 31, 2019.

- **Clarifies the amount that DHHR will pay for court ordered services;**
 - To provide better cost certainty for DHHR, two provisions were added to the code. If a service is currently covered by Medicaid, the court may not order DHHR to pay more than the Medicaid rate for that service. For example, if a court ordered a session with a psychologist, the court then could not order the DHHR to pay more than the Medicaid rate for that session.
 - The same is true for a service not covered by Medicaid and the court orders the service. An example is a drug test. The department shall create a policy which will determine how much more it will pay for the drug test and the court may not order the department to pay more.
 - An exception is placed in both of those sections. The exception permits the court to order a higher rate to be paid, if the services are not provided within 30 days. If the department disagrees, then the department may request a hearing.
- **Changes policies with respect to child residential providers with the goal of retaining placement of children in WV and returning children to WV currently in out-of-state placement;**
 - The bill changes two policies which will affect how foster children are placed in a residential care facility. Residential care facilities are a live-in, out-of-home care placement in which staff are trained to work with children and youth whose specific needs are best addressed in a highly structured environment. These placements are time limited and offer a higher level of structure and supervision than what can be provided in the home.
 - The bill requires a residential child care center to accept a foster child if the child meets their program criteria if the residential child care center has not met its maximum capacity as provided in the contract. These types of facilities are licensed by tiers or levels. A child placed in a tier 1 facility needs less service than a child placed in a tier 3 facility. This change would require a facility which holds itself out as a tier 3 facility to accept all children who need tier 3 services.
 - The bill provides that any residential child care center who has entered into a contract with DHHR may not discharge any child in its program except as provided in the contract including that if the youth does not meet the residential treatment level and target population, the provider shall request a MDT and work toward an alternative placement.
 - The bill provides the court may not order a child to be placed in an out-of-state facility unless the child is diagnosed with a health issue that no in-state facility or program serves, unless a placement out of state is in closer proximity to the child's family for the necessary care or the services are provided more timely.
- **Clarifies the type of assessment performed on a foster child**
 - The code did not differentiate between the type of assessment provided to a juvenile offender and the assessment provided to a foster child. This definition change clarifies that a different assessment should be given to each. A foster child will receive a Child and Adolescent Needs and Strengths Assessment (CANS). The CANS assessment is a multi-purpose assessment developed for children's services to support decision making, including level of care and service planning.

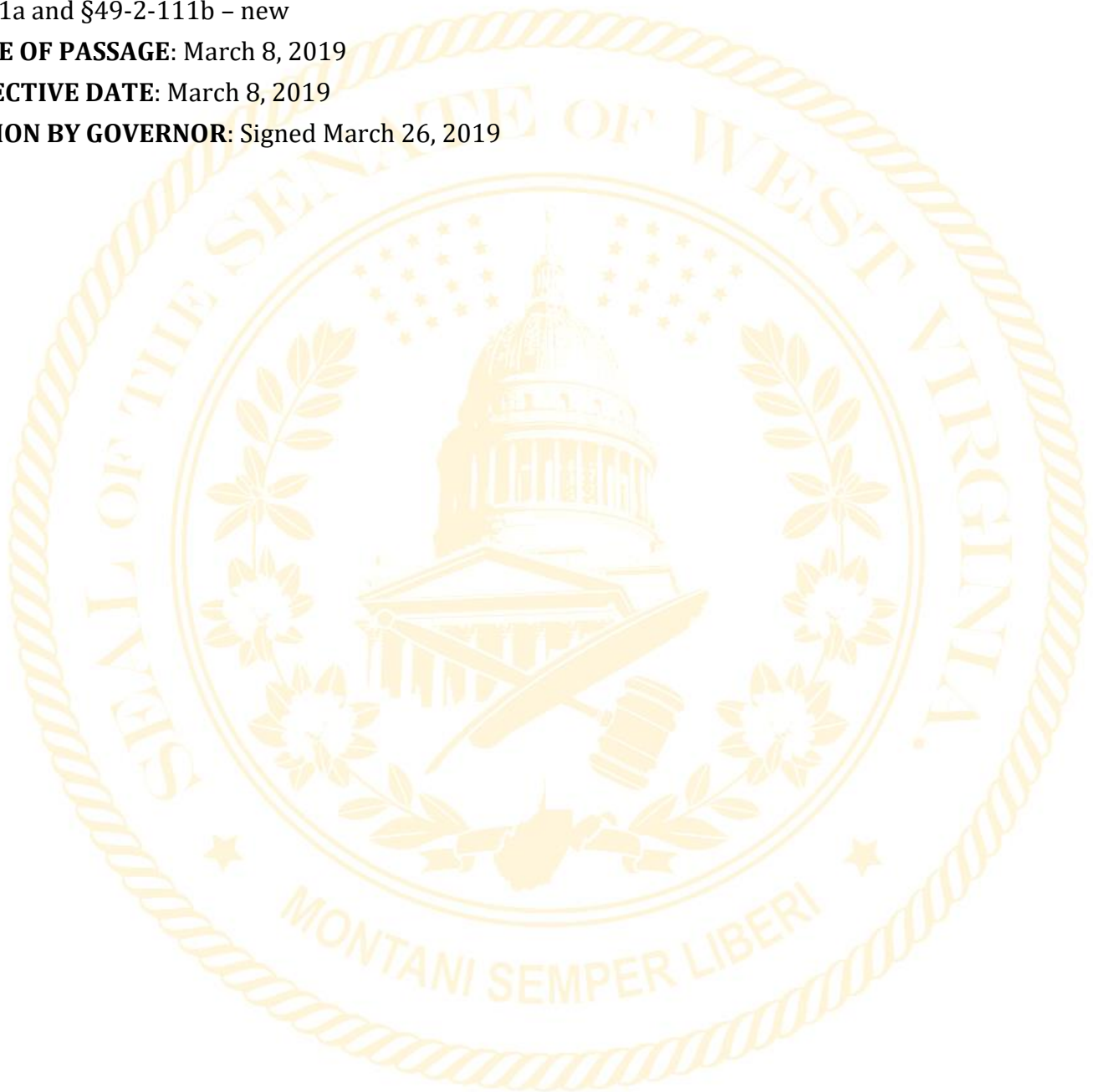
- Juvenile offenders are assessed with the Youth Level of Service Assessment (YLS) Assessment.
- **States that the use of Medication Assisted Treatment may not be the sole reason parental rights may be terminated**

CODE REFERENCE: West Virginia Code §49-1-206, §49-2-107, §49-2-113, §49-2-708; §49-4-108, §49-4-406, §49-4-413, §49-4-604, §49-4-608, §49-4-711, §49-4-714 and §49-5 4-724 – amended; §9-5-27, §49-2-111a and §49-2-111b – new

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: March 8, 2019

ACTION BY GOVERNOR: Signed March 26, 2019



House Bill 2079

Removing certain limitations on medical cannabis grower, processor and dispensary licenses

This bill amends and adds new language to the West Virginia Medical Cannabis Act. The bill:

- Merges definitions of “practitioner and physician” which are used as synonyms in the Act;
- Adds duties for practitioners certifying patients as eligible for medical cannabis;
- Reduces the number of allowable dispensaries from 165 to 100 and allows up to ten dispensary licenses per one person;
- Eliminates the regional dispersion requirement for growers, processors, and dispensaries;
- Establishes criteria for choosing the locations of dispensary permittees;
- Allows vertical integration, i.e. growers and processors can operate and own dispensaries;
- Deals with lab testing of medical cannabis products, providing that:
 - The test must be done under direction of the Bureau of Public Health;
 - The Department of Agriculture must do testing, to the extent practicable;
 - Testing fees shall be deposited in the Agriculture Fee Fund; and
 - The Bureau of Public Health may utilize testers other than the Department of Agriculture, if it determines that the Department is unable perform testing to Bureau requirements;
- Adds language to modify tax provisions to accommodate changes in vertical integration;
- Extends the period for emergency rule-making to July 1, 2021;
- Adds two osteopath physicians to the Advisory Board;
- Indemnifies state employees for attorneys’ fees if criminal charges or civil actions are brought by the federal government, as long as the employee is within the law and scope of employment;
- Requires the Bureau to establish a fair and objective criteria for permit applicants based upon a numeric scoring system;
- Allows for pre-registration of patients prior to July 1, 2019; and
- Removes the requirement that a dispensary have a physician or pharmacist on- site.

CODE REFERENCE: West Virginia Code §16A-2-1, §16A-4-3, §16A-6-13, §16A-7-4, §16A-8-1, §16A-9-1, §16A-10-6, §16A-11-1 – amended; §16A-9-3, §16A-9-4, §16A-15-10 – new

DATE OF PASSAGE: March 9, 2019

PROPOSED EFFECTIVE DATE: March 9, 2019

ACTION BY GOVERNOR: Vetoed March 27, 2019

House Bill 2351

Relating to regulating prior authorizations

The purpose of this bill is to require managed care organizations, private commercial insurers and the Public Employees Insurance Agency to develop prior authorization forms. The bill requires that the forms be developed by October 1, 2019. The health insurers and the Public Employees Insurance Agency shall accept and respond to electronic prior authorization requests by July 1, 2020 if the provider is currently accepting electronic prior authorization requests, then the compliance deadline is January 1, 2020.

The bill provides additional details regarding items that shall be included on the prior authorization form including, containing a comprehensive list of all procedures, services, drugs, devices treatment, durable medical equipment and any other items that may require prior authorization. The form shall delineate those items that may be bundled together as part of the episode of care. The standard for including items on the form is science based using a nationally recognized standard. The list shall be updated regularly.

The bill defines episode of care as a specific medical problem, condition, or specific illness being managed including tests, procedures and rehabilitation initially requested by health care practitioner, to be performed at, the site of service, excluding out of network care: Provided, that any additional testing or procedures related or unrelated to the specific medical problem, condition, or specific illness being managed may require a separate prior authorization.

The deadline for the health insurer to respond to an electronic prior authorization with complete information is within 7 days from the day on the electronic receipt of the request. This timeframe is decreased to 2 days when the request for care could either jeopardize the life, health or safety of the patient or others due to the patient's psychological state or the patient would be subject to adverse health consequences.

The bill makes clear that in the event of incomplete submission of information, the health insurer must identify all deficiencies within 2 business days from the day on the electronic receipt and the health care practitioner shall respond within 3 business days.

The bill provides for a peer to peer review process in the event that the prior authorization request is denied. The bill provides that the peer shall be a health care practitioner similar in specialty, education and background. The bill provides that the health insurer's medical director makes the ultimate appeal determination. The timeframes shall take no longer than 30 days.

The bill provides that any inpatient prescription written at the time of discharge shall not be subject to prior authorization requirements and shall be immediately approved for not less than 3 days. After that timeframe, a prior authorization shall be submitted. Provided the cost of the medication does not exceed \$5,000 per day and the health care practitioner shall not on the prescription or notify the pharmacy that the prescription is being provided at discharge.

The bill provides if medication is to be substituted, then the substituted medication must be of an equivalent class.

The bill provides that in the event that a health care practitioner has performed 30 procedures per year and in a six-month time period and has received 100% prior approval rating, then the health insurer shall not require the health care practitioner to submit a prior authorization for that procedure for the next six months. At the end of the six-month timeframe, the exemption will be reviewed prior to renewal. This exemption is subject to internal auditing by the health insurer at any time and may be rescinded if the

health insurer determines that the health care practitioner is not performing the procedure in conformity with the health insurer's benefit plan based upon the internal audit.

The health insurers must accept prior authorization requests for pharmacy in a specified format by July 1, 2020 or if already accepting electronic prior authorizations January 1, 2020.

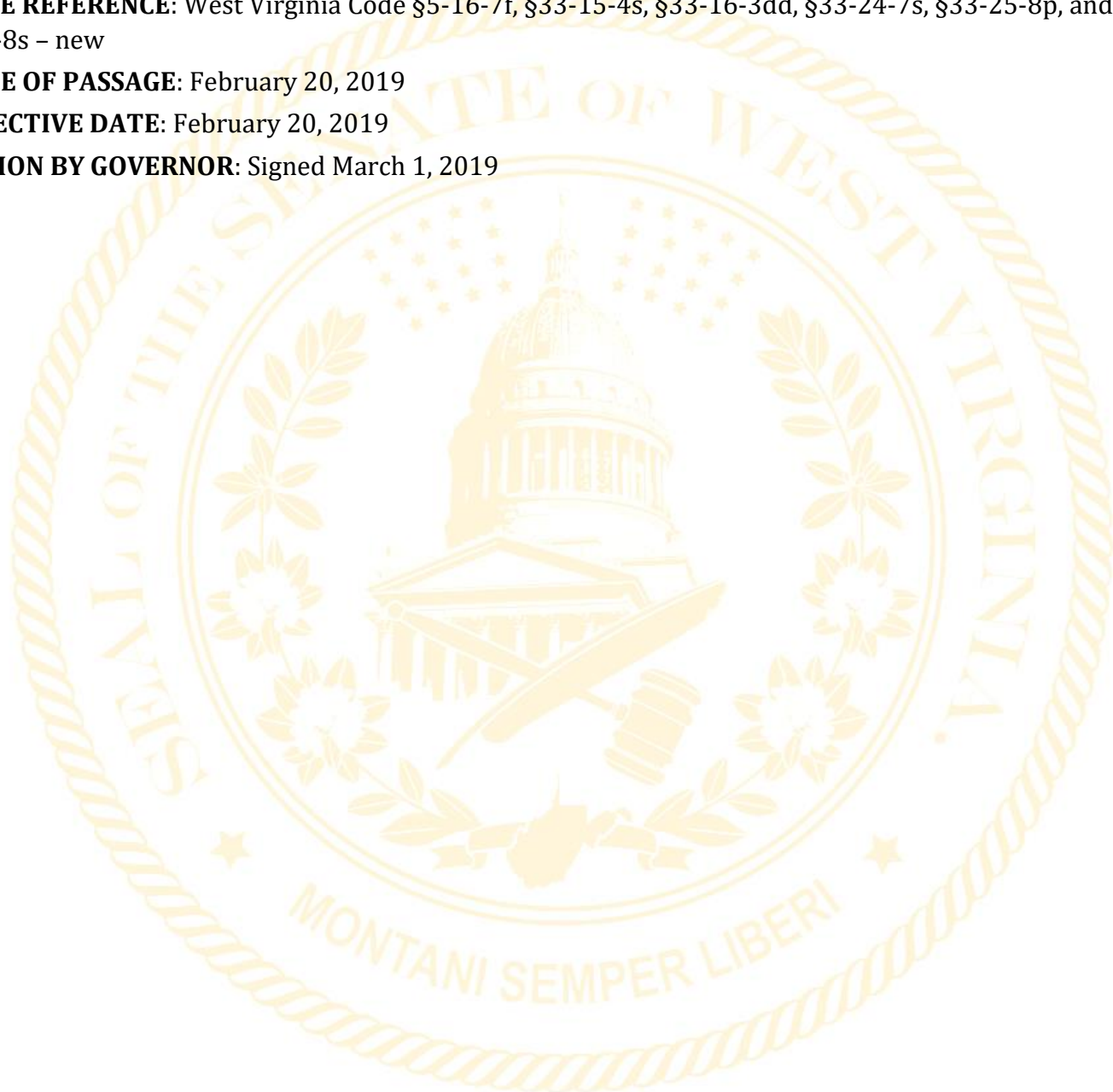
The bill provides that the section is effective for policy, contract, plans, or agreements on or after, January 1, 2020.

CODE REFERENCE: West Virginia Code §5-16-7f, §33-15-4s, §33-16-3dd, §33-24-7s, §33-25-8p, and §33-25A-8s – new

DATE OF PASSAGE: February 20, 2019

EFFECTIVE DATE: February 20, 2019

ACTION BY GOVERNOR: Signed March 1, 2019



House Bill 2405

Imposing a healthcare related provider tax on certain health care organizations

The purpose of the bill is to impose a tiered tax on health maintenance organizations (HMOs) that will permit maximization of federal matching dollars for Medicaid.

The bill amends the definition of broad-based health care related tax to include a health care related tax for which a waiver from the broad based or uniformity requirements has been granted and is in effect by the federal Centers for Medicare and Medicaid Services.

The bill defines the department as the West Virginia Department of Health and Human Resources.

The tax is levied upon health maintenance organizations (HMOs) and shall be collected from every certified HMO. The tax is imposed based upon tiers based upon each taxable health plan's total Medicaid member months within tiers I, II, and III and to non-Medicaid member months within tiers IV and V.

- Tier I-\$17.00 for each Medicaid member month under 250,000;
- Tier II-\$15.00 each Medicaid member month between 250,000 and 500,000;
- Tier III-\$7.00 for each Medicaid member month greater than 500,000;
- Tier IV-\$.025 for each non- Medicaid member month under 150,000; and
- Tier V-\$0.10 for each non-Medicaid member month of 150,000 or more.

The bill adds definitions for Managed care organization, Managed care plan, Medicaid member, Medicaid member months, non-Medicaid enrollee, non-Medicaid member months and taxable health plan.

The tax shall be effective for three years beginning on the first day of the state fiscal year following a 30-day period after the secretary has posted notice on the department Internet website that approval had been received from the federal Centers for Medicare and Medicaid Services that the tax imposed is permissible.

The tax shall be void if the Centers for Medicare and Medicaid Services determines that it is no longer eligible for federal financial participation. The tax shall remain in effect only until June 30, 2022 and as of this date is repealed.

No taxes may be collected until the DHHR receives written notice that the federal Centers for Medicare and Medicaid Services has approved proposed Medicaid rates as actuarially sound for the taxable year in which the tax will be imposed.

CODE REFERENCE: West Virginia Code §11-26-1 through §11-26-17, §11-26-19, and §11-26-20 – repealed; §11-27-3 – amended; §11-27-10a – new

DATE OF PASSAGE: March 6, 2019

EFFECTIVE DATE: June 4, 2019

ACTION BY GOVERNOR: Signed March 27, 2019

House Bill 2474

Relating to a reserving methodology for health insurance and annuity contracts

This bill amends W. Va. Code §33-7-9, West Virginia's "Standard Valuation Law," which authorizes a principle-based reserving methodology for life, annuity, and health policies.

West Virginia adopted the National Association of Insurance Commissioners' (NAIC) updated, model-based Standard Valuation Law in 2014. However, a small section of the model law pertaining to the minimum standard for accident and health insurance contracts was inadvertently omitted in the 2014 update.

The bill ensures that W. Va. Code §33-7-9 is internally consistent and that life insurance companies are properly calculating their reserves for accident and health insurance contracts.

In this context, the term "accident and health insurance" refers to contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions. These are not comprehensive health insurance policies. These are limited benefit type policies written by life insurers, such as disability, accident, and sickness plans.

This is a revision or update to a NAIC Model Law that is an accreditation standard for state insurance departments effective January 1, 2020.

CODE REFERENCE: West Virginia Code §33-7-9 – amended

EFFECTIVE DATE: June 7, 2019

DATE OF PASSAGE: March 9, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 2492

Relating to mandatory reporting procedures of abuse and neglect of adults and children

The purpose of the bill is to permit the Department of Health and Human Resources (DHHR) to have discretion to develop various methods to allow the reporting of the abuse of incapacitated adults or facility residents or of an emergency situation involving an adult. Additionally, the change will allow flexibility in the reporting of child abuse and neglect matters. Currently, all matters are reported via telephone to centralized intake. This bill requires the DHHR to maintain a system of reporting that will allow immediate assistance for emergency situations if it moves to a web-based reporting system.

CODE REFERENCE: West Virginia Code §9-6-11 and §49-2-809 – amended

DATE OF PASSAGE: February 19, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: Signed February 28, 2019

House Bill 2524

Permitting a pharmacist to convert prescriptions authorizing refills under certain circumstances

The bill provides a pharmacist with authority to convert prescriptions authorizing refills in specified circumstances.

If a prescription is written that authorizes a drug to be dispensed by refilling the prescription one or more times and the total quantity of the drug does not exceed an 90 day supply, a pharmacist who is filing or refilling the prescription may dispense a quantity that varies from the quantity or amount of the drug originally written on the prescription if all of the following specified conditions are met:

- The action taken by the pharmacist does not result in a quantity or amount of the drug being dispensed that exceeds the total quantity that may be dispensed by filling and refilling the prescription;
- The prescription is for (a) a maintenance drug, (b) a drug to prevent disease, or (c) a contraceptive;
- If the prescription is for a maintenance drug, the patient used the initial 30-day supply of the drug, or a 90-day supply of the drug has previously been prescribed to the patient, and the pharmacist determines, that the drug has stabilized the condition;
- The prescription is not for a controlled substance; and
- The pharmacist consults with the patient and determines the action authorized is appropriate for the patient.

The bill permits a pharmacist to substitute the same drug in a different dose if the aggregate dose remains the same and the following conditions are met: the pharmacist counsels the patient on the differences, the pharmacist notifies the patient's prescriber of the drug product substitution within 5 business days.

In the event of an emergency, a pharmacist may distribute or sell a dangerous drug, other than a Schedule II controlled substance, without a written or oral prescription from a licensed health professional if all of the following conditions are met:

- The pharmacy has a record of the prescription for the drug in the name of the patient who is requesting it, but it does not provide for a refill;
- The pharmacist is unable to obtain authorization to refill the prescription from a health care professional who issued the prescription or another health professional responsible for patient's care;
- In the exercise of the pharmacist's professional judgment, the drug is essential to the life of the patient or continue therapy for a chronic condition of the patient and failure to dispense or sell the drug to the patient could result in harm to the patient;
- Except as provided in this section, the amount of the drug that is dispensed or sold does not exceed a 72 hours supply; and
- If not a controlled substance and patient has been on a consistent drug therapy, the amount of the drug dispensed or sold does not exceed a 30-day supply as provided in the prescription or if the drug standard exceeds a 30-day supply, the amount of the drug dispensed does not exceed the standard unit for dispensing. A pharmacist shall not dispense or sell a particular drug to the same patient more than once in any 12-month period.

A pharmacist who dispenses for sells a drug under this section shall:

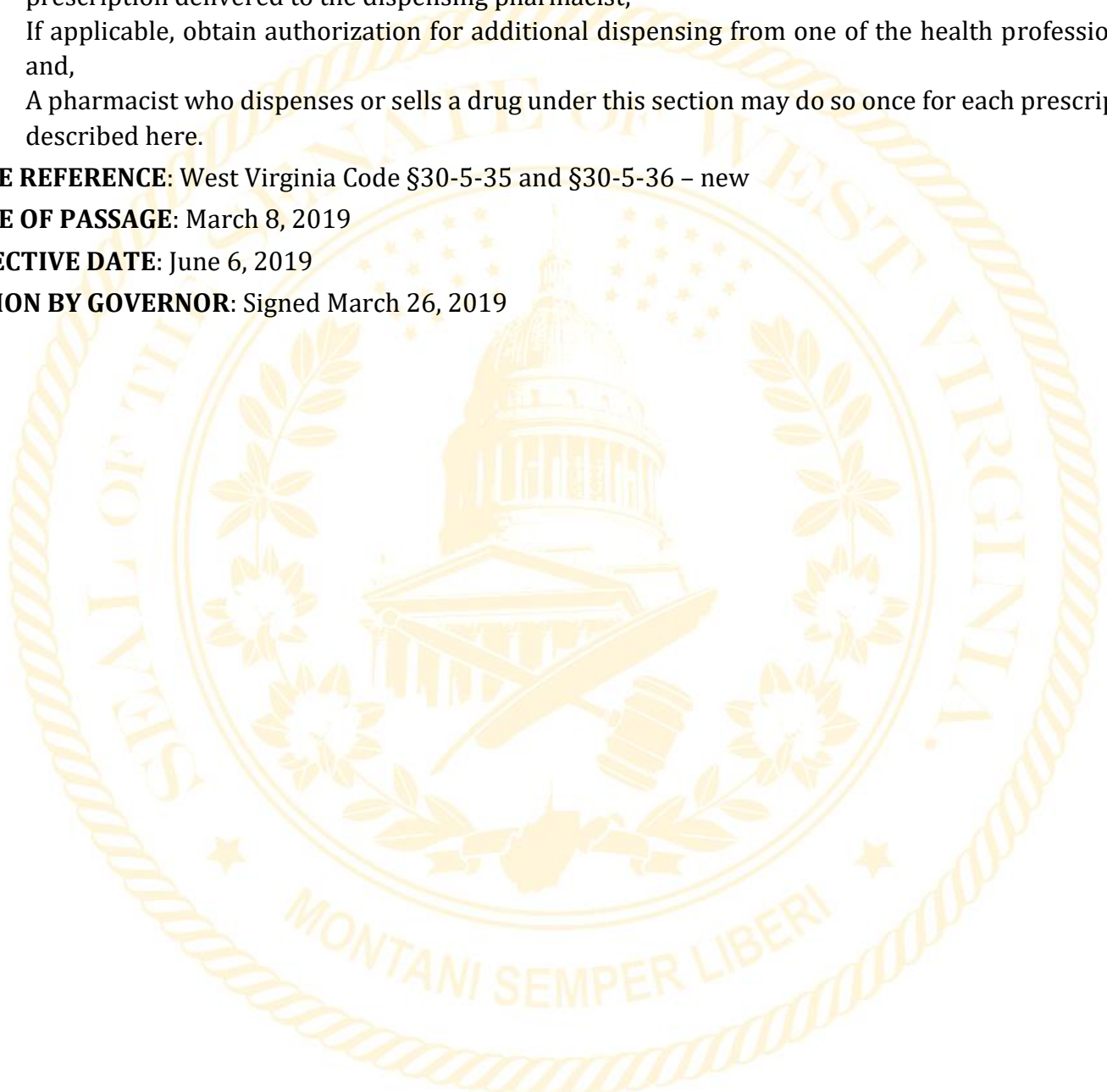
- For 1 year after the date of dispensing or sale, maintain a record of the drug sold or dispensed, including the name and address of the patient, the amount dispensed or sold, and the original prescription number;
- Notify the health professional who issued the initial prescription or another health professional responsible for the patient's care no later than 72 hours after the drug is sold or dispensed; and, within 7 days after authorizing an emergency oral prescription, the practitioner has a written prescription delivered to the dispensing pharmacist;
- If applicable, obtain authorization for additional dispensing from one of the health professionals; and,
- A pharmacist who dispenses or sells a drug under this section may do so once for each prescription described here.

CODE REFERENCE: West Virginia Code §30-5-35 and §30-5-36 – new

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed March 26, 2019



House Bill 2525

Tobacco Cessation Therapy Access Act

The bill permits but does not require a pharmacist to dispense a non-controlled prescription medication, over-the-counter medication, or other professional service to a patient who is 18 years old or older pursuant to a standing order without any prescription drug order from a person licensed to prescribe tobacco cessation therapy.

The Commissioner of the Bureau of Public Health or designee shall prescribe on a statewide basis a tobacco cessation therapy by one or more standing order permitting pharmacists to initiate the dispensing of noncontrolled prescription medications, over-the-counter medications, or other professional services to eligible individuals.

A standing order must specify, at a minimum:

- use of the tobacco cessation therapy protocol that has been approved by the Commissioner of the Bureau of Public Health in collaboration with the Board of Pharmacy and the Board of Medicine;
- the eligible individuals to whom the tobacco cessation therapy may be dispensed;
- the timeline for renewing and updating the standing order.

The Board of Pharmacy shall approve a training program to be eligible to participate in the utilization of the standing prescription drug order for tobacco cessation therapy by a pharmacist and documentation shall be provided to the Board of Pharmacy upon request.

A dispensing pharmacist shall follow the Tobacco Cessation Therapy Protocol that has been approved by the Commissioner of the Bureau of Public Health in collaboration with the Board of Pharmacy and the Board of Medicine before dispensing the tobacco cessation therapy.

The protocol shall include:

- criteria for identifying individuals eligible to receive the tobacco cessation therapy or other professional services under the protocol and referral to an appropriate prescriber if the patient is high-risk or therapy is contraindicated;
- medications authorized;
- procedures for initiation and monitoring of therapies, including a care plan;
- education requirements to be provided to eligible individual;
- documentation procedures in the pharmacy system;
- notification of the individuals primary care provider;
- if it is unsafe to dispense a tobacco cessation therapy to a patient, the pharmacist may not dispense the tobacco cessation therapy and shall refer the patient to their primary care provider.

The Board of Pharmacy regulates a pharmacist who dispenses a tobacco cessation noncontrolled prescription medication, over-the-counter medication, or other professional service.

CODE REFERENCE: West Virginia Code §16-56-1 through §16-56-6 – new

DATE OF PASSAGE: March 6, 2019

EFFECTIVE DATE: June 4, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 2583

Family Planning Access Act

The purpose of the bill is to permit a pharmacist to dispense a self-administered hormonal contraceptive to a patient under a standing order(s) in accordance with a protocol consistent with the United States Medical Eligibility Criteria for Contraceptive Use (MEC) Centers for Disease Control and Prevention. A pharmacist may dispense the hormonal contraceptive pursuant to the standing order without a prescription drug order from a person licensed to prescribe the contraceptive. A pharmacist may dispense a self-administered hormonal contraceptive pursuant to a standing order, in accordance with the dispensing guidelines, and to a patient who is 18 years old or older. The state health officer may prescribe the contraceptive on a statewide basis by one or more standing orders consistent with the United States Medical Eligibility Criteria for Contraceptive Use, Centers for Disease Control that requires the following:

- Use of the self-screening risk assessment questionnaire;
- Written and oral education;
- The timeline for renewing and updating the standing order;
- Who is eligible to utilize the standing order; and,
- The pharmacist to make and retain a record of each person to whom the self-administered hormonal contraceptive is dispensed.

The Board of Pharmacy, in conjunction with the Bureau for Public Health, shall approve a training program to be eligible to participate in the utilization of the standing prescription drug order for self-administered hormonal contraceptives by a pharmacist. The participation is voluntary. The bill does not create a duty or standard of care for a person to prescribe or dispense a self-administered hormonal contraceptive. This bill provides guidelines for dispensing a self-administered hormonal contraceptive. A participating pharmacist who dispenses self-administered hormonal contraceptives:

- shall obtain a completed self-screening questionnaire that has been approved by the state health officer;
- notify the individual's primary care provider, if provided;
- if when dispensing within the guidelines it is unsafe to dispense a self-administered hormonal contraceptive to a patient, then the pharmacist may not dispense the contraceptive and must refer to a health care practitioner or local health department;
- may not continue to dispense a self-administered hormonal contraceptive to the patient for more than 12 months without evidence that the patient has consulted with a health care practitioner; and,
- shall provide the patient with written and verbal information regarding the importance of seeing a health care practitioner and the effectiveness of long-term reversible contraceptives; and shall provide the patient with a copy of the record of the encounter.

The pharmacist shall counsel the patient regarding self-administration, side effects, the need for back up contraception, and when to seek emergency medical attention. The Board of Pharmacy regulates a pharmacist who dispenses a self-administered hormonal contraceptive.

CODE REFERENCE: West Virginia Code §16-57-1 through §16-57-6 – new

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 2607

Relating to the licensure of nursing homes

This bill clarifies rule requirements and the process to be followed by applicants seeking a license; the clinical, medical, resident, and business records to be kept by the nursing home; the procedures and inspections for the review of utilization and quality of resident care and the procedures for informal dispute resolution, independent informal dispute resolution and administrative due process, and when such remedies are available.

This bill adds the following new definitions: “Director” means director of OHFLAC; “Person” means an individual and every form of organization, whether incorporated, including any partnership, corporation, trust, association, or political subdivision of the state; and “Secretary” means the Secretary of DHHR. Throughout the bill the word “director” was replaced with the word “secretary.” The Secretary is directed to establish a number of legislative rules on various topics including the following:

- To ensure compliance with §29A-3-11(b)(3) the secretary shall amend his or her legislative rule to exempt federally certified Medicare and Medicaid nursing facilities from provisions addressed in the federal regulations;
- The process to be followed by applicants seeking a license;
- The clinical, medical, resident, and business records to be kept by the nursing home;
- The procedures and inspections for the review of utilization and quality of resident care;
- The procedures for informal dispute resolution.

A licensee no longer is required to file a balance sheet, a statement of operations or financial disclosure when seeking license renewal.

If the nursing home handles any money for residents within the facility, the licensee shall file a bond or obtain insurance in a sum 1.25 times the average amount of funds deposited with the nursing home during the nursing home’s previous fiscal year. Nursing homes certified to accept payment by Medicare and Medicaid must meet the requirements for surety bonds as listed in the applicable federal regulations.

The bill clarifies that the Board of Review and not the director issues a final order regarding an assessment. The bill provides the Secretary with authority to deny or limit a license if he or she finds upon inspection that there has been a substantial failure to comply with the provisions of this article or the standards or rules promulgated pursuant hereto.

The bill provides for a standard administrative process as contemplated by the administrative procedures act. Judicial review is within 30 days after receiving notice of the decision in Kanawha County Circuit Court. An appeal from an adverse decision may be appealed to the WV Supreme Court of Appeals.

The bill removes several employment restrictions and provides that all employees must be subject to the WV Cares screening.

CODE REFERENCE: West Virginia Code §16-5C-16 and §16-5C-17 – repealed; §16-5C-2, §16-5C-4 through §16-5C-22 – amended

DATE OF PASSAGE: February 20, 2019

EFFECTIVE DATE: May 21, 2019

ACTION BY GOVERNOR: Signed March 1, 2019

House Bill 2768

Reducing the use of certain prescription drugs

The purpose of this bill is to clarify portions of the Opioid Reduction Act.

The bill replaces references to opioid throughout the bill with Schedule II opioid drug. The bill clarifies that a prescription for a Schedule II opioid drug to an adult patient in the ER for outpatient use is not considered to be an initial Schedule II prescription.

The bill does not change the time frames for prescriptions. For example, an adult patient seeking treatment in an urgent care facility setting for outpatient use can have no more than a four-day supply. A dentist or an optometrist may not issue the prescription for more than a three-day supply. A practitioner, other than a dentist or optometrist, may not issue an initial Schedule II opioid prescription for more than a seven-day supply.

Prior to issuing the initial prescription, existing law requires that the practitioner conduct a physical examination. The bill states that the examination should be relevant to the specific diagnosis and course of treatment and should assess whether the course of treatment would be safe and effective for the patient. Prior to issuing a subsequent prescription, existing law requires a practitioner conduct a physical examination. The bill provides that the physical exam should be relevant to the specific diagnosis and course of treatment and should assess whether continuing the course of treatment would be safe and effective for the patient. The bill clarifies that in conjunction with the issuance of the third prescription the patient shall execute a narcotics contract with their prescribing practitioner. The bill lists the minimum information that the contract is required to contain. The bill provides that a pharmacist is not responsible for enforcing the provisions of this section and the Board of Pharmacy may not discipline a licensee if he or she fills a prescription in violation of the provisions of this section.

The bill creates a new exception wherein this article does not apply to a patient being prescribed, or ordered any medication in an inpatient setting at a hospital. The bill provides that notwithstanding the limitations on prescribing earlier in the article, a practitioner may prescribe an initial seven-day supply post-surgery. With respect to the treatment of pain, the bill provides that when the patient seeks treatment, a health care practitioner shall refer or prescribe as is appropriate based on the practitioner's clinical judgment and the availability of the treatment, before starting a patient on a Schedule II opioid. There is no cap on the number of visits for physical therapy, occupational therapy, osteopathic manipulation and chiropractic services, which may be order.

The licensed health care practitioner providing services pursuant to this section may prescribe within their scope of practice. A health care practitioner referral, although permitted, is not required as a condition of coverage by the Bureau of Medical Services, the Public Employees Insurance Agency and any insurance provider who offers an insurance product in this state.

CODE REFERENCE: West Virginia Code §16-54-1, §16-54-3, §16-54-4, §16-54-5, §16-54-6, §16-54-7, and §16-54-8 – amended

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 2770

Fairness in Cost-Sharing Calculation Act

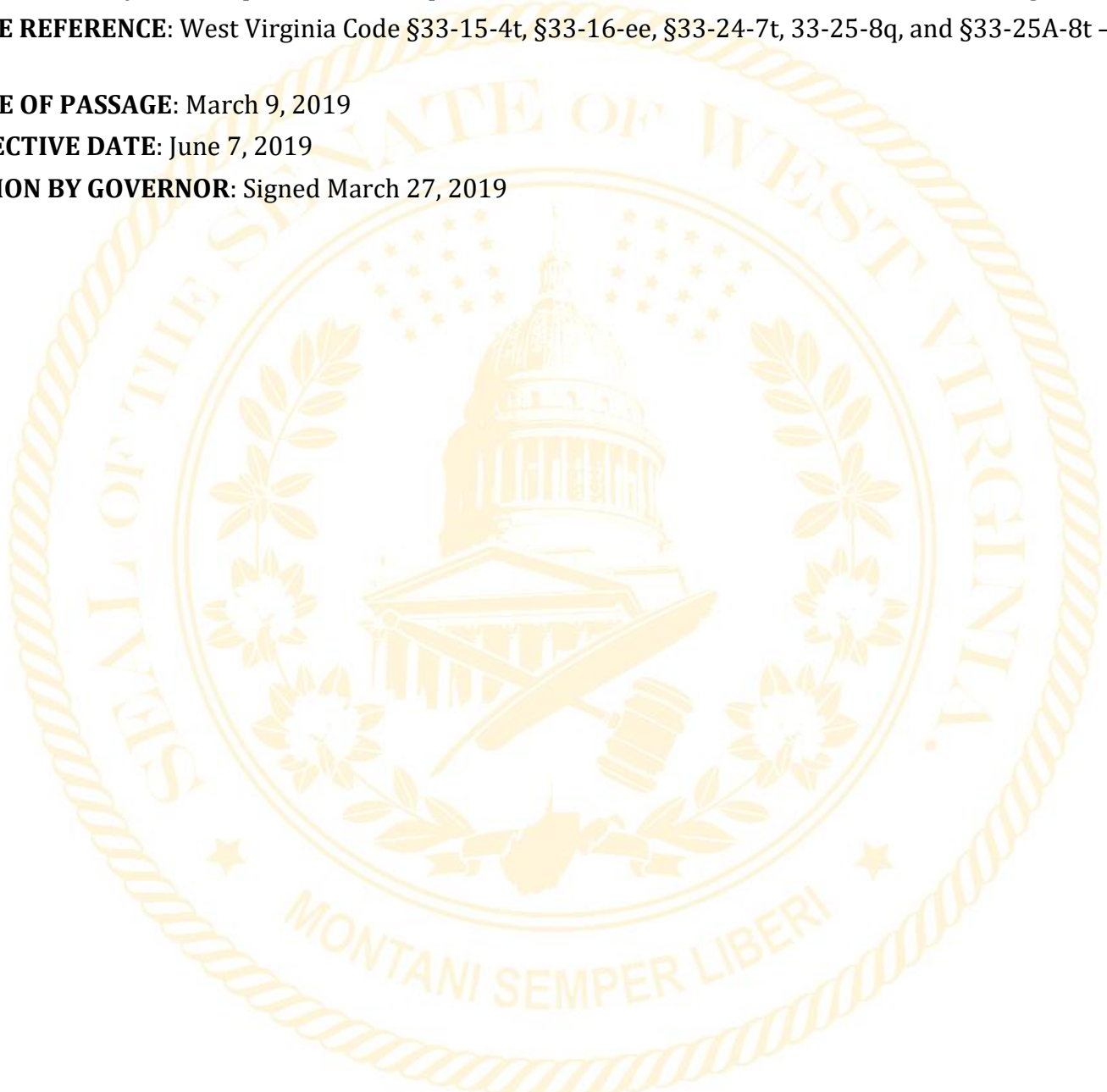
The bill requires an insurer to include a cost sharing amounts paid by the insured or on behalf of the insured by another person when calculating an insured's contribution or deductible. The bill also requires a pharmacy benefits manager (PBM) to include any cost sharing amounts paid by the insured or on behalf of the insured by another person. The bill provides the Insurance Commission with rulemaking authority.

CODE REFERENCE: West Virginia Code §33-15-4t, §33-16-ee, §33-24-7t, 33-25-8q, and §33-25A-8t – new

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed March 27, 2019



House Bill 2849

Establishing different classes of pharmacy technicians

The bill sets standards for a pharmacy technician to obtain a nuclear technician endorsement. An applicant for this endorsement shall complete the following:

- submit a written application to the board;
- pay applicable fees;
- have graduated from high school or obtained a Certificate of General Education (GED) or equivalent;
- have successfully completed a pharmacy provided, competency-based nuclear pharmacy technician education and training program approved by the board;
- have all applicable national certifications and comply with all federal rules and regulations;
- not be an alcohol or drug abuser; provided that an applicant in an active recovery process may be considered;
- not have been convicted of a felony within 10 years preceding the date of the application;
- not have been convicted of a misdemeanor or felony in any jurisdiction bearing a nexus to the practice of pharmacist care; and
- have fulfilled any other requirements specified by the board.

If the pharmacy technician obtains a nuclear pharmacy technician endorsement, the technician may under the direct supervision of the licensed nuclear pharmacist perform specified duties, including assist in dispensing process; receive new written drug or electronic prescription drug orders, mix compound ingredients for liquid products, suspensions, ointments, or blends for tablet granulations and capsule powers, and prepare radiopharmaceuticals among other listed duties. The bill sets forth an additional scope of practice for pharmacy technicians. Current law provides that a pharmacy technician shall under the direct supervision of the licensed pharmacist, perform specified duties.

This bill adds the following items:

- complete a list of a patient's current prescription and nonprescription medications to provide for medication reconciliation and supervise records screening;
- perform pharmacy technician product verification where no clinical judgment is necessary and the pharmacist makes the final verification if the registered pharmacy technician furnishes to the Board an affidavit signed and dated by the supervising pharmacist in charge attesting to the applicant's competency in the advanced areas of practice that he or she will practice and has either worked as a full time registered pharmacy technician holding a pharmacy technician endorsement in WV for at least the previous 2 years or worked as a full time registered pharmacy technician holding a pharmacy technician license in good standing in another jurisdiction for at least the previous two years.

The bill provides that a pharmacy technician may not provide an act within the practice of pharmacist care that involves discretion or independent professional judgment or a function which the registrant has not been trained and the function has not been specified in a written protocol with competency established.

CODE REFERENCE: West Virginia Code §30-5-11 and §30-5-12 – amended

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 2947

Relating generally to telemedicine prescription practice requirements and exceptions

The purpose of this bill is to permit a telemedicine prescription of a Schedule II drug in a hospital setting for immediate administration, excluding the emergency department.

CODE REFERENCE: West Virginia Code §30-3-13a and §30-14-12d – amended

DATE OF PASSAGE: March 9, 2019

EFFECTIVE DATE: June 7, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 3132

Relating to exempting providers that serve no more than 30 patients with office-based medication-assisted treatment

The purpose of the bill is to exempt a person, partnership, association or corporation providing office based, medication assisted treatment to no more than 30 patients of their practice or program from registration requirements including compliance with associated legislative rules regulating office-based medication assisted treatment programs and to exempt behavioral health providers from registration and rule compliance.

In place of the registration process, the providers are required to file an attestation with the Office of Health Facility Licensure and Certification that it has completed medical education training on addiction treatment encompassing all forms of medication-assisted treatment, in addition to existing requirements in the code. The provider must also attest that they will provide information related to patient health and safety to OHFLAC upon request.

The bill provides that a licensed behavioral health center, providing office-based medication-assisted treatment is exempt from the registration requirements in code.

In place of the registration process, the providers are required to file an attestation with the Office of Health Facility Licensure and Certification attesting that the provider: requires counseling and drug screens, has implemented diversion control measures, will provide patient numbers upon request and will provide any other information required by the secretary related to patient health and safety. The provider must notify OHFLAC prior to establishing or terminating an office-based medication-assisted treatment program at any other licensed behavioral health center location.

CODE REFERENCE: West Virginia Code §16-5Y-4 – amended

DATE OF PASSAGE: March 8, 2019

EFFECTIVE DATE: June 6, 2019

ACTION BY GOVERNOR: Signed March 26, 2019

House Bill 118

Relating to the use of post-criminal conduct in professional and occupational initial licensure decision making

At the time of this bill, various professional and occupational boards regulated by Chapter 30 of the Code did not address prior criminal convictions in a uniform manner for purposes of evaluating initial license applications. This bill prohibits boards (with certain boards excluded) from disqualifying an applicant for licensure because of a prior criminal conviction unless that conviction is for a crime that bears a rational nexus to the profession or occupation requiring licensure. The bill also prohibits boards from disqualifying an applicant for licensure based on a prior conviction of a crime generally described as one of “moral turpitude.” The following professions, and their respective boards, are excluded from the new requirements: Attorneys; Doctors of Medicine; Physician’s Assistants; Osteopathic Physicians; Private Investigators and Security Service Providers; and Law-Enforcement Officers.

The bill also requires a board to allow an applicant to apply for initial licensure after five years have passed from the date of conviction or date of release from incarceration, if the applicant has not been convicted of any other crime during that time period and the underlying offense was not of a violent or sexual nature. A board must allow a potential applicant, prior to submitting an application, to petition a board for a determination of whether the individual’s criminal record will disqualify the individual from obtaining a license and the board must respond to the petition within 60 days.

Finally, the bill requires boards to promulgate legislative rules incorporating the new requirements within the applicable time limit to be considered by the Legislature during its regular session in 2020.

House Bill 118 and Senate Bill 1011 were introduced during the First Extraordinary Session of the Legislature in 2019, to address the Governor’s veto of House Bill 2486, which was passed by the Legislature during the Regular Session but subsequently vetoed by the Governor. The Governor’s veto message raised concerns about the lack of criteria provided for a board or licensing authority to determine whether a rational nexus exists between a criminal conviction and an occupation. The veto message also raised concerns that the bill limited ability of boards and licensing agencies to consider statutorily required criminal background check results, based on the rational nexus requirement. The modified bill provides guidance on the criteria for finding a rational nexus, but also provides that those criteria are “minimum” standards, giving boards and licensing authorities the discretion to consider additional factors that are unique to the relevant occupation.

CODE REFERENCE: West Virginia Code §30-1-24 – new

DATE OF PASSAGE: June 17, 2019

EFFECTIVE DATE: June 17, 2019

ACTION BY GOVERNOR: June 28, 2019

Senate Bill 1006

Authorizing Board of Physical Therapy conduct criminal background checks on applicants for licenses

In 2018, the West Virginia Board of Physical Therapy joined the Physical Therapy Licensure Compact, as codified at §30-41-1 et seq.

As part of participation in the Compact, and, particularly, the Compact Commission's data system, each state must implement a background check requirement, including obtaining results from the Federal Bureau of Investigation. The FBI is now declining to perform such background checks if a member state does not have statutory authorization for the FBI to perform such checks.

This bill provides the Board of Physical Therapy authority to conduct criminal background checks so that it may continue to participate in the Compact. Applicants must pay the costs of the background check and must complete it as soon as possible after applying for licensure. The results of the check are confidential, and are not subject to disclosure under the Freedom of Information Act.

The bill restricts the board's use of a prior conviction to disqualify applicants from licensure. It allows applicants disqualified from licensure because of a prior conviction to reapply after five years after the later of the date of conviction or the date of release from the penalty imposed because of the conviction, except for convictions for violent or sexual offenses.

The bill also allows individuals with criminal records to petition the board before applying for a license for a determination whether his or her criminal record will disqualify the individual from obtaining a license.

Note: The substantive provisions of this bill are identical to the enrolled version of SB 633 from the Regular Session. The only change to the bill is the amendment of the title to address the technical defect stated in the Governor's veto message for SB 633. The Senate passed the bill by a vote of 33-0-1. The House amended the bill and passed it by a vote of 98-0-2. The Senate concurred in the House amendment and passed the bill 34-0, completing legislative action. The Governor vetoed the bill on March 27, 2019, on the ground that the title had a defect. This bill corrects the title defect.

CODE REFERENCE: West Virginia Code §30-41-4 – new

DATE OF PASSAGE: May 20, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: Signed May 29, 2019

Senate Bill 1009

Establishing health professionals' student loan programs

This bill creates two programs to assist in the recruitment of physicians. The first program is a loan repayment to be administered by the Higher Education Policy Commission. The loan repayment program shall help repay the student loans for mental health providers who provide therapy and counseling services and who reside in WV and work in an underserved area of WV for up to three years beginning January 1, 2020. Individuals participating in the loan repayment program may be eligible to receive up to \$30,000 to be dispersed in a program award of up to \$10,000 each year in exchange for the participant completing one year of practice in an underserved area; a participant may not receive a program award for more than three years of practice; a participant must direct each award received toward the repayment of her or her education loans. The bill creates a special revenue fund to be used to accomplish the purposes of this subsection

The bill also creates a second program to assist in recruiting physicians. This program creates a non-resident medical student partial tuition waiver as a means of recruiting practicing physicians to underservice areas and to primary care and practitioner shortage areas in WV. It will be known as the non-resident medical student tuition regularization program to be administered by the vice chancellor for Health Sciences in cooperation with the three medical schools in the state. Two non-resident medical students from each medical school in the state are selected annually to participate in the program subject to exceptions noted in the amendment. Each student is charged the state resident tuition for each academic year and has the cost differential between the resident and non-resident rates waived by the institution at which he or she is enrolled. For each academic year he or she participates in the program, he or she shall commit to render services for one calendar year as a medical doctor or a doctor of osteopathy in this state in a medically under-served area or in a primary care or specialty practice field in which there is a shortage of physicians. The amendment sets forth eligibility for the program, penalties for failure to satisfy service commitment, and provides for the commission to develop a policy to implement the provisions of this subsection.

This bill was passed by the Senate by a vote of 34-0 and passed by the House by a vote of 95-4 with 1 member not voting during the 2019 Regular Session. This bill was vetoed by the Governor on March 27, 2019, because the title was defective. The title noted that the bill authorized legislative rules to be filed but the bill authorized the Commissioner of the Higher Education Policy Commission to promulgate rules. The bill was corrected to reflect that the Commissioner will promulgate policy, not rules, as reflected in the title.

CODE REFERENCE: West Virginia Code §18C-3-3 – amended; §18C-3-5 – new

DATE OF PASSAGE: May 20, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: May 29, 2019

Senate Bill 1012

Creating a voluntary certification for recovery residences

The bill establishes standards for certification of recovery residences. It defines terms including;

Recovery residence means a single family, drug free and alcohol-free residential dwelling unit, or other form of group housing that is offered or advertised by any person or entity as a residence that provides a drug free and alcohol-free living environment for the purpose of promoting sustained, long-term recovery from substance abuse.

DHHR shall contract with an entity to serve as the certifying agency for voluntary certification of the certified recovery residences based upon standards determined by the National Alliance for Recovery Residences (NARR) or similar entity. DHHR shall establish an accreditation program that:

- upholds industry best practice and support a safe, healthy and effective recovery environment;
- evaluate the residence's ability to assist persons in achieving long-term recovery, and;
- protect residents against unreasonable and unfair practices in setting and collecting fee payments.

The bill provides the documentation that the recovery residence shall submit: This includes:

- documentation verifying certification as administered by the certifying agency;
- if the municipality or county where the recovery residence is located requires compliance with local building, maximum occupancy, fire safety and sanitation code applicable to single family residence this documentation of compliance must be submitted;
- the municipality or county must perform the inspection within 30 days of receiving a request for verification if the municipality or county requires verification of compliance with local building, maximum occupancy, fire safety, and sanitation codes applicable to single family homes;
- upon receiving the certification application, the certifying agency shall evaluate to determine if the residence is in compliance with best practice standards and safety requirements. Additionally, any application of the items specified in this section must comply with the Fair Housing Act and that Americans with Disabilities Act.

If the residence is in compliance, the certification agency shall issue the certification of compliance. The bill provides that each residence location, even if operated by the same person or entity must maintain a certificate of compliance.

The bill provides for a suspension or revocation process. Suspension or revocation may take place after a notice of deficiency is served and has existed for at least 30 days. An entity suspended or revoked may apply for an be granted reinstatement. A fee of \$100.00 may be charged for re-inspection if the certification was revoked for non-compliance with local building, maximum occupancy, fire safety, and sanitation codes.

DHHR shall periodically evaluate the quality, integrity and efficiency of the accreditation program. The bill provides that DHHR shall develop rules to implement this section and for receiving complaints against recovery residences.

The bill provides that a recovery residence may not be advertised as a "certified recovery residence" unless the recovery residence has a certificate of compliance. The bill provides that if a person violates the subsection is guilty of a misdemeanor and a fine of not less than \$1000 nor more than \$5000. For each infraction.

The certifying agency shall publish, maintain and disseminate a list of drug and alcohol free housing certified pursuant to this section. The list shall be disseminated to DHHR for use by each state agency or

vendor with a statewide contract that provides substance use disorder treatment services. The list shall be published on the website maintained by the certifying agency.

The DOC, Parole Board, county probation, day report centers, municipal courts, and a medical or clinical treatment facility that receives funds for its operations may not make a referral of any prisoner, parolee, probationer, prospective, current or discharged patient or client to a recovery residence unless the recovery residence hold a valid certificate of compliance. No recovery residence is eligible to receive funds from any source within the state treasury unless it holds a valid certificate of compliance. The bill provides for record keeping for agencies receiving funding and making referrals to recovery residences. The bill provides that a person who violates this section is guilty of a misdemeanor punishable by a fine of not less than \$500.00 nor more than \$1000.

This bill was passed by the Senate by a vote of 34-0 and passed by the House by a vote of 98-0 with 2 members not voting during the 2019 Regular Session. This bill was vetoed by the Governor on March 27, 2019, because the legislation granted rulemaking authority to the undefined “certifying agency” who acts as a contractor to DHHR. This could be a governmental agency but if awarded to a for profit business or nonprofit, the force of law could not be provided to a private entity. In correcting the veto message, the rulemaking authority is vested with DHHR.

CODE REFERENCE: West Virginia Code §16-59-1, §16-59-2 and §16-59-3 – new

DATE OF PASSAGE: May 20, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: Signed May 29, 2019

Senate Bill 1013

Permitting trained nurses to provide mental health services in a medication-assisted treatment program

The bill sets forth operational requirements for medication assisted treatment programs. The existing language of the bill provides that each medication assisted treatment program shall designate counseling staff which meet the requirements of this article and the rule. The proposed bill adds a psych-mental health nurse practitioner or a psych-mental health clinical nurse specialist and Psychiatry CAQ certified physician assistants to the list of professionals who can provide counseling services in a MAT program.

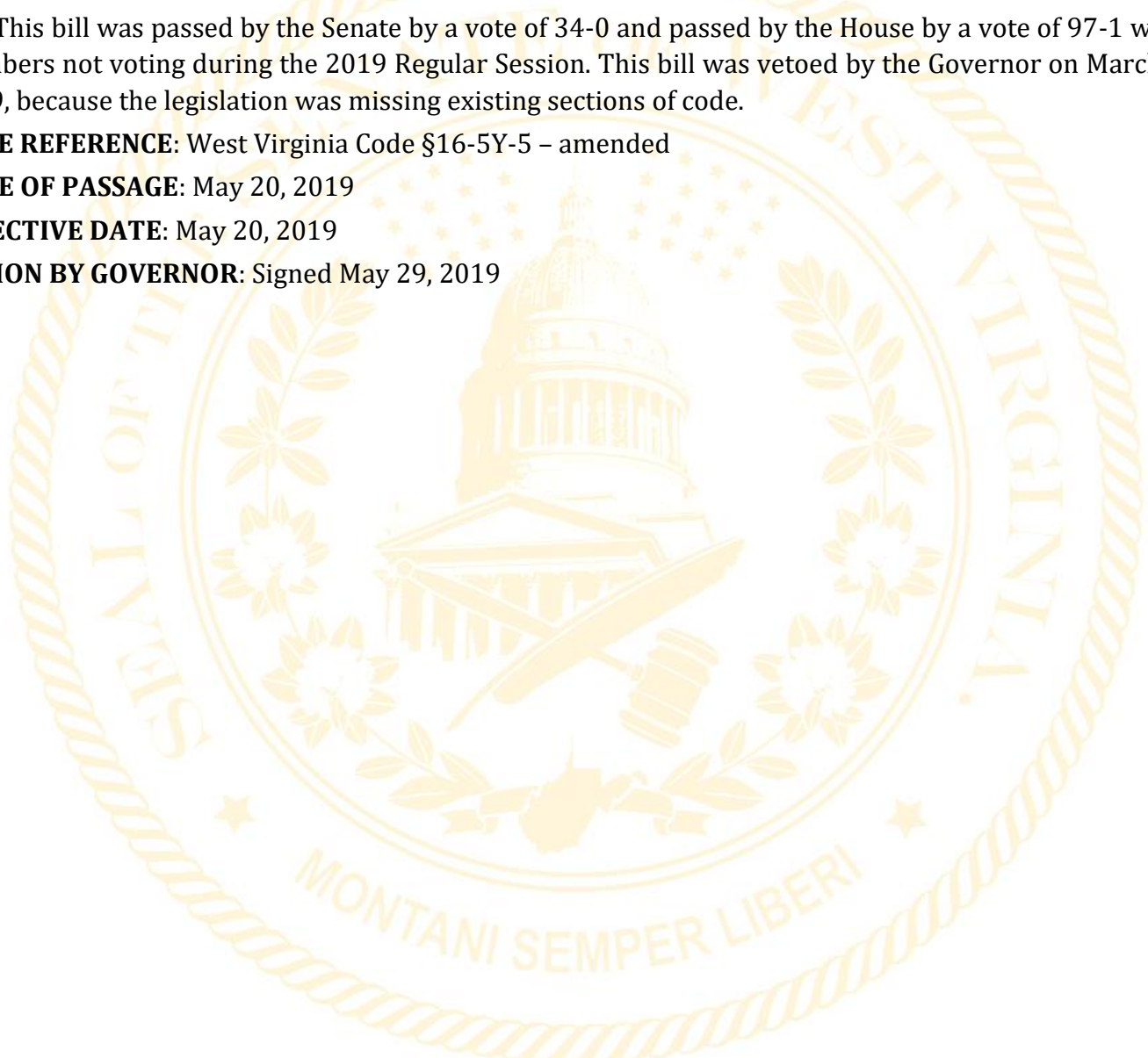
This bill was passed by the Senate by a vote of 34-0 and passed by the House by a vote of 97-1 with 2 members not voting during the 2019 Regular Session. This bill was vetoed by the Governor on March 27, 2019, because the legislation was missing existing sections of code.

CODE REFERENCE: West Virginia Code §16-5Y-5 – amended

DATE OF PASSAGE: May 20, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: Signed May 29, 2019



Senate Bill 1037

Relating generally to medical cannabis

The bill, which was introduced and passed by the Legislature as House Bill 2079 during the 2019 Regular session, amends and adds new language to the West Virginia Medical Cannabis Act. The bill:

- Merges definitions of “practitioner and physician” which are used as synonyms in the Act;
- Adds duties for practitioners certifying patients as eligible for medical cannabis;
- Reduces the number of allowable dispensaries from 165 to 100 and allows up to ten dispensary licenses per one person;
- Eliminates the regional dispersion requirement for growers, processors, and dispensaries;
- Establishes criteria for choosing the locations of dispensary permittees;
- Allows vertical integration, i.e. growers and processors can operate and own dispensaries;
- Deals with lab testing of medical cannabis products, providing that:
 - The test must be done under direction of the Bureau of Public Health;
 - The Department of Agriculture must do testing, to the extent practicable;
 - Testing fees shall be deposited in the Agriculture Fee Fund; and
 - The Bureau of Public Health may utilize testers other than the Department of Agriculture, if it determines that the Department is unable to perform testing to Bureau requirements;
- Adds language to modify tax provisions to accommodate changes in vertical integration;
- Extends the period for emergency rule-making to July 1, 2021;
- Adds two osteopath physicians to the Advisory Board;
- Indemnifies state employees for attorneys’ fees if criminal charges or civil actions are brought by the federal government, as long as the employee is within the law and scope of employment;
- Requires the Bureau to establish a fair and objective criteria for permit applicants based upon a numeric scoring system;
- Allows for pre-registration of patients prior to July 1, 2019; and
- Removes the requirement that a dispensary have a physician or pharmacist on-site.

In this newly introduced version, the bill addresses the issue for which the Governor issued a veto – the vertical integration tax structure. The tax is now a 10 percent privilege tax and it is at the dispensary level, and nowhere else in the vertical integration hierarchy. Additionally, the lab testing provision to allow independent, private labs with no expressed or implicit authority for the Commissioner of Agriculture to be a participant in that testing process.

CODE REFERENCE: West Virginia Code §16A-2-1, §16A-4-3, §16A-6-13, §16A-7-4, §16A-8-1, §16A-9-1, §16A-10-6, §16A-11-1 – amended; §16A-9-3, §16A-9-4, §16A-15-10 – new

DATE OF PASSAGE: May 20, 2019

EFFECTIVE DATE: May 20, 2019

ACTION BY GOVERNOR: Vetoed March 27, 2019

2018 Regular Session



Senate Bill 46

Permitting pharmacists to inform customers of lower-cost alternative drugs

This bill permits a pharmacy or pharmacists have a right to provide covered individuals with information related to lower cost alternatives, as well as cost share for the covered individuals. It prohibits a PBM from penalizing a pharmacy or pharmacist for providing information about lower cost alternatives to covered individuals if such information is available and prohibits PBMs from charging a co-pay to an insured individual that would exceed the total actual charges submitted by the pharmacy or pharmacist to the PBM.

A PBM may charge a fee to a pharmacy or pharmacist so long as the total amount of the fee is apparent at the point of sale or the total amount of the fee is identified, reported, and explained on the admittance advice report of the adjudicated claim.

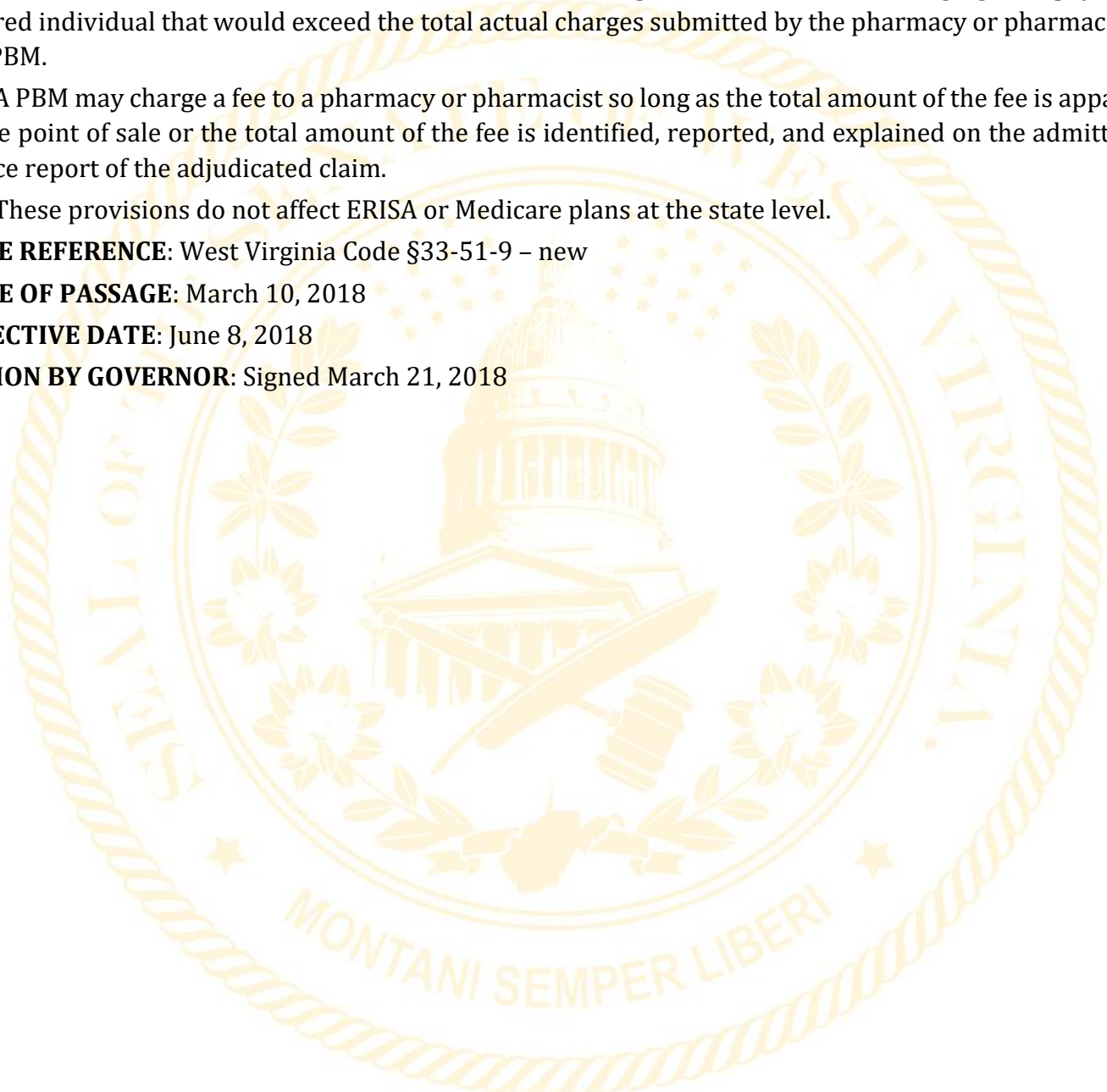
These provisions do not affect ERISA or Medicare plans at the state level.

CODE REFERENCE: West Virginia Code §33-51-9 – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 21, 2018



Senate Bill 165

Authorizing the Department of Health and Human Resources promulgate legislative rules

This bill contains 13 rules proposed by the Department of Health and Human Resources and two rules which the Department requested be repealed, which constitute Bundle 5. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health and Human Resources, Hospital Licensure, 64 CSR 12

This is an amendment to an existing rule. It pertains to the licensing of hospitals and extended care facilities. The changes to the rule are to update the rule to current practice.

A number of updates include referenced documents which have been updated since the rule was last amended in 2006. These include the National Electric Code and the Standards for Health Care Facilities adopted by the Centers for Medicare and Medicaid Services. There have also been a number of updates regarding references to other state rules.

The rule also eliminates the provision which allowed hospitals to have four (4) beds per patient room. The current industry standard is a maximum of two (2) which provides for better patient care. It also eliminates the need to keep records of stillborn infants separate from the mother's records. Finally, it requires all long term acute care hospitals to meet standards set by the Centers for Medicare and Medicaid Services relating to long term acute care facilities.

Department of Health and Human Resources, Emergency Medical Services, 64 CSR 48

This is an amendment to an existing rule regarding emergency medical services. The changes to the rule are in three places.

First, the rule alters the manner in which ground ambulances are to have reflective markings. They are replacing the current language with national standards set out by the Commission on Accreditation of Ambulance Services. This was a recommendation of the Emergency Medical Services Advisory Council. The current standards were considered outdated and had the potential to cause harm. Additionally, newer models of ambulances have made these requirements difficult to meet.

The second change was to repeal the section pertaining to local systems. It was the opinion of the agency that the Department had no authority in the statute to regulate such entities. The enabling statute allowed county commissions to provide emergency medical transport and to regulate those. That statute is West Virginia Code §7-15-1 which does not provide any oversight authority to DHHR over county commissions.

The final changes are to the fees which have been increased as much as 100% to 200% percent to account for the change from an annual certification to one every two (2) years thereby causing a decrease in revenue. These fees changes are to account for the decrease in revenue caused by the change from an annual to a biennial license.

Fiscal Impact: The rule contains an increase in fees for persons subject to the provisions of the rule. The increase in fees is in response to the action of the Legislature in 2016 in Senate Bill 195 which modified the certification process. In that bill (which authorized changes to the EMS Rule) the certification period was changed from one year to two years. The justification for the fee increase is that this change in the certification process has resulted in significantly lower revenue from fees.

The fee increases are as follows:

An applicant for Emergency Medical Vehicle Operator, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse applicants shall pay the following non-refundable certification fees to be deposited in the Emergency Medical Services Agency Licensure Fund:

- Initial certification via National Registry or state examination, includes fingerprint processing there is a fee increase from \$50.00 to \$100.00.
- Recertification via National Registry maintenance or state process there is a fee increase from \$25.00 to \$75.00.
- Emergency Medical Dispatcher applicants fee:
 - Initial application there is a fee increase from \$25.00 to \$75.00; and
 - Recertification there is a fee increase from \$25.00 to \$50.00.
- Fee for certification modification there is a fee increase from \$5.00 to \$25.00.
- Late recertification application (within 90 days of expiration date), there is a fee increase from \$25.00 to \$50.00.

The Department indicates these fee increases will result in an increase in revenue in 2017 of \$112,500 and an increase thereafter of \$150,000 per year.

After meeting with the agency, the decided to alter the fees in rule as follows:

- Withdraw the fee increased for the dispatchers in subsection 6.9. It was to be increased from \$25.00 to \$75.00.
- Reduce the fee increase for certification modification in §6.10 from \$25.00 to \$10.00.
- Reduce the late fee for a late application for recertification in §6.12 back to the current \$25.00.
- 6.8.a. Initial certification via National Registry or state examination was proposed to increase to \$100 from \$50.00 it is not proposed to only increase to \$75.00.
- 6.8.b. Recertification via National Registry maintenance or state process was to increase from \$25.00 to \$75.00. That will now be proposed to increase to \$37.50.
- 6.8.c. Legal recognition will remain at \$100.
- 6.8.e. National Criminal Background Check: \$45.00. This is a new fee. Previously OEMS has simply taken the cost of the background check (\$45.00) out of the initial certification fee or the recertification fee, whichever is applicable. Under the current rule, the OEMS charges a certification fee of \$50. After paying the State Police for the background check, OEMS is left with just \$5.00. It is worse if the background check is necessary at the time of recertification. In that case the applicant for recertification is charged \$25.00. The OEMS must pay the State Police \$45.00 for the background check, leaving the OEMS with a negative \$20, which is paid out the office's budget Thus, the OEMS is subsidizing applicants for the cost of a mandatory background check.
- 6.10. Fee for certification modification had been \$5.00. It was proposed to increase that to \$25.00. They are now proposing a change to \$10.00.

Department of Health and Human Resources, WV Clearance for Access: Registry and Employment Screening, 69 CSR 10

This rule pertains to the WV Clearance for Access: Registry and Employment Screening program. This is a program to provide for pre-employment screening for certain facilities which are subject to the act pursuant to the provisions of West Virginia Code §16-49-1 (a)(4). These facilities include skilled nursing

facilities, nursing facilities, home health agencies, hospice, long-term care hospitals, personal care providers, adult day care providers and certain residential care providers.

This is an amendment to an existing rule. It simply adds to the list of disqualifying offenses which exclude an applicant from direct access those offenses listed in our code as felony crimes against the peace and felony traffic offenses. Felony crimes against the peace include aiding a convicted felon in an attempt to escape, intimidation of a witness in conspiracy prosecutions, mob or riotous assemblage with infliction of damage or injury to a person, false reporting of bombs, violence against a person for race, color, religion, ancestry, national origin, political affiliation or sex, and certain terrorist acts. The serious traffic offenses added as a disqualifying event include negligent homicide, driving under the influence and reckless driving.

The rule also changes the designation of an employee from “conditional” to “provisional” pending receipt of the background check. This makes the rule consistent with the statute.

Department of Health and Human Resources, Development of Methodologies to Examine Needs for Substance Use Disorder Treatment Facilities within the State, 69 CSR 13

This bill was made necessary with the passage last session of House Bill 2428. The rule is new. The rule sets out the procedure to assess the needs for substance abuse beds throughout the state in an evidence based and data informed manner.

The rule contains the standard Scope, Authority, Filing and Effective Date, Sunset Provision and Purpose section. It also has a Background section which explains the genesis of the rule.

Key terms are defined in the rule. These include a list of regions whereby the state is divided into geographic regions to allow the Department through the Bureau for Behavioral Health and Health Facilities to conduct an assessment of the needs and demand by region for ease in administration. The needs assessment will be based upon direct measures, indirect measures and ethnographic study. The Bureau is required by the rule to consult with various entities including the newly created Office of Drug Control Policy which was created in the legislation that prompted this rule.

The House of Delegates amended this rule to reconfigure the regions for disbursement of substance use funds from the Ryan Brown Fund. The amendment simply increased the number of regions from six to seven regions.

Department of Health and Human Resources, Collection and Exchange of Data Related to Overdoses, 69 CSR 14

This rule sets out the process for exchange of various entities with the newly created Office of Drug Control Policy. That office was established with the passage of House Bill 2620 during the 2017 Regular Session of the Legislature. The enacting legislation required the exchange of necessary data. The necessity of the data is to operate a database on fatal and non-fatal overdoses.

The rule is new. It contains the standard Scope, Authority, Filing and Effective Date and Sunset Provision. It also has an applicability section which sets out the entities which are subject to the data exchange. These include various state entities, law enforcement, health care providers, emergency responders, pharmacies and medical examiners. The rule defines key terms.

Substantively the rule requires mandatory reporters as that term is defined in the rule to report electronically or on Department provided forms reportable information as set out in the rule. The Office of Drug Control Policy is permitted to disclose the reported data for legitimate purposes relative to public health to Participants – also defined. The data is to be utilized to develop policies and best practices to prevent substance abuse.

The bill sets out the powers and duties of the Director of the Office of Drug Control Policy relative to the data. This includes determinations regarding request for access, maintaining the data in a secure manner and responding appropriately to requests. The rule also sets out a number of privacy concerns and security safeguards. This includes the way in which a breach of policy shall be managed.

Department of Health and Human Resources, Financial Disclosure Rule, 65 CSR 13

This rule updates the financial reporting requirements as required by House Bill 117 adopted during the First Special Session of 2017. The rule sets forth what data a covered facility or, if requested, a related organization is required to report. These reports shall contain the annual financial report; prepared by an accountant or auditor; reports of services rendered; the Health Care Authority Financial Report through the Uniform Reporting System; and a current Uniform Bill form for each inpatient. This is data that has been reported in the past.

The required data to be no longer required to be reported includes: a statement of ownership of persons owning more than 5% of the capital stock; dividends paid and to whom; a disclosure of ownership by a parent company; a statement of services available; a statement of the total financial needs of the facility; resources available to cover the needs; copies of reports filed with the Federal Health Care Financing Administration; a statement of all charges, fees or salaries for goods or services that exceed \$55,000; a statement of all charges, fees or other sums collected which exceed \$55,000; and tax returns.

A failure to comply with the required reporting requirements would result in a fine of \$1000 per day.

Department of Health and Human Resources, Child Care Licensing, 78 CSR 01

This rule sets out the standards and procedures for licensing child care centers. This is an amendment to an existing rule.

The changes to the rule made the rule compliant with the Child Care Development Block Grant reauthorization. This would require child care center providers to receive criminal background checks prior to licensing as a child care center. The center would bear the cost of the criminal background check. In West Virginia, these background checks would be subject to the WV CARES program which was adopted by the Legislature in Senate Bill 88 during the 2015 Regular Session of the Legislature.

The rule makes some changes to definitions necessitated by the Child Care Development Block Grant and also updates existing language regarding criminal background checks to account for the fact that these will now be processed through the WV CARES program and to make the language consistent with federal law.

Department of Health and Human Resources, Family Child Care Facility Licensing Requirements, 78 CSR 18

This rule sets out the standards and procedures for licensing family child care centers. This is an amendment to an existing rule.

The changes to the rule made the rule compliant with the Child Care Development Block Grant reauthorization. This would require family child care providers to begin paying for criminal background checks for prospective employees. In West Virginia, these background checks would be subject to the WV CARES program which was adopted by the Legislature in Senate Bill 88 during the 2015 Regular Session of the Legislature.

The rule makes some changes to definitions necessitated by the Child Care Development Block Grant and also updates existing language regarding criminal background checks to account for the fact that these

will now be processed through the WV CARES program and to make the language consistent with federal law.

Department of Health and Human Resources, Family Child Care Home Registration Requirements, 78 CSR 19

This rule sets out the standards and procedures for registering family child care homes. This is an amendment to an existing rule.

The changes to the rule made the rule compliant with the Child Care Development Block Grant reauthorization. This would require family child care provider and adult household member to receive criminal background checks prior to registration as a family child care home. In West Virginia, these background checks would be subject to the WV CARES program which was adopted by the Legislature in Senate Bill 88 during the 2015 Regular Session of the Legislature.

The rule makes some changes to definitions necessitated by the Child Care Development Block Grant and also updates existing language regarding criminal background checks to account for the fact that these will now be processed through the WV CARES program and to make the language consistent with federal law.

Department of Health and Human Resources, Informal and Relative Family Child Care Home Registration Requirements, 78 CSR 20

This rule sets out the standards and procedures for regulating informal and relative family child care homes. This is an amendment to an existing rule.

The changes to the rule make the rule compliant with the Child Care Development Block Grant reauthorization. That grant requires criminal background checks for a caregiver and any adult household member through the WV CARES program. The background check is current law. These changes would allow for that check to be done through the WV CARES program. The program was adopted by the Legislature in Senate Bill 88 during the 2015 Regular Session of the Legislature.

The rule makes some changes to definitions necessitated by the Child Care Development Block Grant, also updates existing language regarding criminal background checks to account for the fact that these will now be processed through the WV CARES program and to make the language consistent with federal law. Finally, it updates the section regarding immunizations to make it consistent with current state law.

Department of Health and Human Resources, Out of School Time Child Care Center, 78 CSR 21

This rule sets out the standards and procedures for licensing child care centers who operate an out of school time program. This is an amendment to an existing rule.

The changes to the rule made the rule compliant with the Child Care Development Block Grant reauthorization. This would require child care providers to begin paying for criminal background checks for prospective employees. In West Virginia, these background checks would be subject to the WV CARES program which was adopted by the Legislature in Senate Bill 88 during the 2015 Regular Session of the Legislature.

The rule makes some changes to definitions necessitated by the Child Care Development Block Grant and also updates existing language regarding criminal background checks to account for the fact that these will now be processed through the WV CARES program and to make the language consistent with federal law.

Department of Health and Human Resources, Pilot Program for Drug Screening of Applicants for Cash Assistance, 78 CSR 26

This rule implements the provisions of Senate Bill 6 which passed during the 2016 Regular Session of the Legislature. That bill required the Department of Health and Human Resources to develop a three (3) year pilot program to conduct substance use testing upon applicants for Temporary Assistance to Needy Families.

This is a new rule. It defines necessary terms. Many of these terms are lifted directly from the authorizing statute. Included in the defined terms is the term “reasonable suspicion”. This would be determined from a questionnaire provided to applicants at the time of their application for benefits. A prior conviction for a drug offense is also considered reasonable suspicion. The definition of this term reflects what is set out in statute.

The bill also sets out a process for conducting a drug screen based upon the use of a screening questionnaire. If reasonable suspicion is found after completion of the questionnaire, the applicant shall have seven (7) days to submit to a drug test. The rule does, however, provide that the caseworker may extend this time if unforeseen circumstances exist. The rule sets out the duties of the caseworker upon receipt of the drug test which includes notice to the applicant of the results. There is also an exception should the drug be prescribed, and the applicant can provide proof.

A negative test allows the application to proceed with their benefit case. Upon receipt of a positive test, the caseworker is required to work with the applicant to set up treatment. There is a similar exception for unforeseen circumstances as is included in the portion of the rule regarding drug tests. During treatment, regular updates are required to the caseworker by the treatment program. The applicant remains subject to random drug tests upon completion of treatment.

Any applicant who does not adhere to the treatment plan is ineligible for assistance. Any applicant who fails a second drug test post-treatment is ineligible for assistance for a period of twelve months or completion of a second treatment plan, whichever period is shorter. A third positive screen would result in a lifetime ban.

There are provisions for alternative payees to allow children in the household to receive benefits should their parent be ineligible for assistance as a result of a positive drug test. The alternative payee – in the rule it is referred to as a “protective payee” – is subject to the same drug screen and testing requirements as the applicant and may be subject to audits by the Department regarding the manner in which they spend the benefits for the child or children.

The rule provides for a referral and investigation by Child Protective Services for applicants who have terminated or suspended benefits due to a positive drug test. There is also the right to appeal a decision by the applicant aggrieved by any action of the Department. Records of the drug screen and tests are to remain confidential.

Department of Health and Human Resources, Regulation of Opioid Treatment, 69 CSR 7 – Repealed

This rule has been superseded by 69 CSR 11 and 69 CSR 12.

Department of Health and Human Resources, Certificate of Need Rule, 65 CSR 7 – Repealed

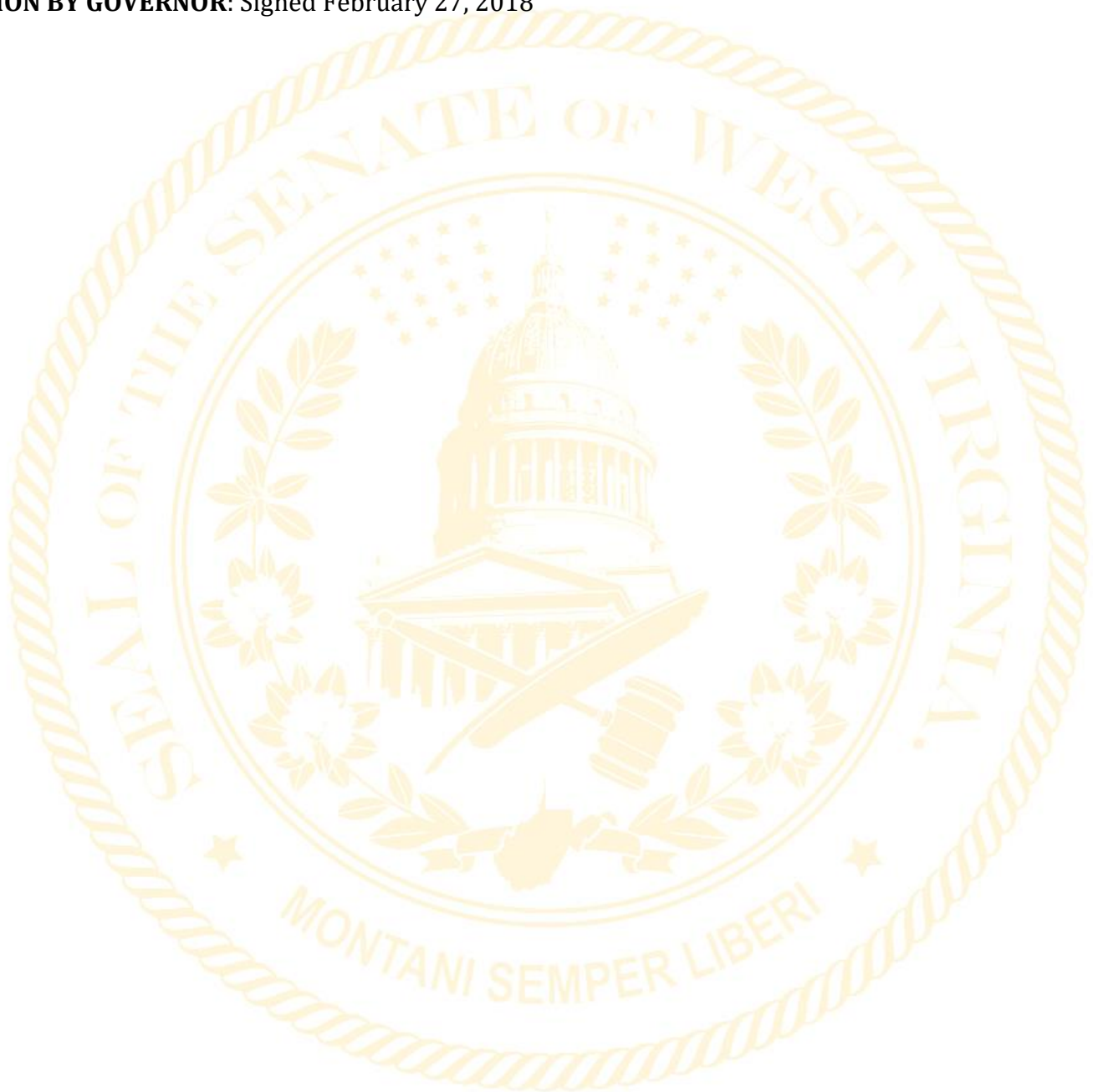
This rule has been superseded by 65 CSR 32.

CODE REFERENCE: West Virginia Code §64-5-1 and §64-5-2 – amended

DATE OF PASSAGE: February 19, 2018

EFFECTIVE DATE: February 19, 2018

ACTION BY GOVERNOR: Signed February 27, 2018



Senate Bill 242

Requiring health insurance providers provide coverage for certain Lyme disease treatment

The bill requires insurance plans offered in West Virginia to require coverage for long-term antibiotic coverage for Lyme Disease.

The bill requires that prior to payment that:

- The long-term antibiotic coverage by a licensed physician; and,
- Completion of a thorough examination of the patient's symptoms, test results, or response to other treatment.

CODE REFERENCE: West Virginia Code §33-6-38, §33-15-4p, §33-16-3zz and §3325A-8p – new

DATE OF PASSAGE: March 8, 2018

EFFECTIVE DATE: June 6, 2018

ACTION BY GOVERNOR: Signed March 20, 2018

Senate Bill 272

Relating generally to drug control

The bill requires “confirmed” overdoses to be reported the Office of Drug Control Policy; and added emergency rooms to the list of entities required to report overdoses.

The bill also establishes the Community Overdose Response Demonstration Pilot Project, whose purpose is to develop community programs that focus on existing resources of government agencies to create outreach programs to educate the community, including first responders, on recognizing and responding to opioid overdoses. Communities that experience a high frequency of drug overdoses compared to national averages as determined by the Office of Drug Control Policy are eligible to participate. Participants in the program are required to report progress made under the pilot project to the Director.

Finally, the bill requires antagonist training for first responders and also requires that local and state agencies who employ first responders provide them with opioid antagonists if funding is available.

CODE REFERENCE: West Virginia Code §16-5T-4 and §16-46-4 – amended; §16-5T-6 and §16-46-7 – new

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Approved on March 27, 2018

Senate Bill 273

Reducing use of certain prescription drugs

This bill creates the Opioid Reduction Act. The bill defines terms. The bill provides for an advance directive to allow persons to voluntarily request not to be prescribed or treated with an opioid. The bill further requires that a practitioner must counsel a patient prior prescribing to inform them of the option to request a lesser quantity of any opioid prescribed and to inform them of the risks associated with the prescribed opioid. The bill sets forth the following limitations regarding opioid prescription:

- After an Emergency Room visits, a four-day supply may be prescribed;
- After an urgent care visit, a four-day supply may be prescribed, but a seven-day supply may be prescribed if there is a medical rationale for more than a four-day supply. The medical rationale must be documented in the medical record.
- For a minor, a three-day supply may be prescribed after a required discussion with the parents or guardian;
- A dentist or optometrist may prescribe a three-day supply;
- A physician may not issue more than an initial seven-day supply; and
- A veterinarian may not issue more than an initial seven-day supply.

The bill also codifies a current legislative rule requirement, that Schedule II drugs may be prescribed for 30 days at a time with two additional prescriptions for 30 days; however, for each subsequent prescription, the prescribing practitioner must access the Controlled Substances Monitoring Database and examine the patient after 90 days. There is also a requirement that the practitioner and a patient execute a narcotics contract for prescribing any Schedule II drugs. The contract is required to provide that the patient will only seek these drugs from the physician who is prescribing them, that they will only have them filled at one pharmacy of their choosing, that if in emergency situations they are administered a Schedule II drug, they will notify the doctor within 24 hours. Breaking the contract could result in the termination of the patient/doctor relationship or in the physician discontinuing prescription of Schedule II drugs.

Definition of a Pain Clinic

Current law provides that if more than 50% of the patients of a medical practice are being prescribed a controlled substance, the medical practice is classified as a pain clinic. To make certain drugs that are alternatives to opioids available, this bill provides that only the percentage of patients prescribed Schedule II controlled substances counts toward a medical practice's classification as a pain clinic.

Initial Prescription

Prior to issuing an initial prescription, a practitioner is required to conduct and document a complete medical history. The practitioner must also conduct and document a physical examination, develop a treatment plan, and access the Controlled Substances Monitoring Database.

Subsequent Prescription

The bill sets out requirements for subsequent prescription. These requirements include that the patient has knowledge that a prescription is not an initial prescription, that the practitioner determines the opioid is necessary and appropriate, and that the prescription does not present undue risk of abuse or addiction. The practitioner is also required to discuss the risks of addiction and overdose, the reasons why the prescription is necessary, and alternative treatments and general risks including potential drug and

alcohol interactions. Compliance with these requirements must be recorded in the patient's medical record.

Third Prescription

A third prescription requires a practitioner to consider referral to a pain clinic or a pain specialist, however, the patient may opt to remain a patient of the practitioner. If the relationship continues, the practitioner is required to review the course of treatment every three months to assess new information and progress, assess the patient for dependence and document the same, make efforts to stop using or decrease the dosage of the controlled substance unless contraindicated, try other drugs or treatment options and document the same, and review the Controlled Substances Monitoring Database.

Exceptions

There are specific exceptions to limitations on opioid prescription for new patients who are in active cancer treatment, hospice care, residents of long-term care facilities, or being prescribed medication in rehabilitation. There is also an exception which allows for a seven-day supply of opioids after surgery, within the medical discretion of the practitioner. The bill provides that alternative methods shall be prescribed or recommended as an alternative to prescribing an opioid. These methods include physical therapy, occupational therapy, massage therapy, and chiropractic services. There is also a provision requiring insurance coverage for these therapies. Finally, the bill provides that a violation of the article by a practitioner may be grounds for a professional disciplinary action.

Controlled Substances Monitoring Database (CSMD)

The CSMD has been updated to require reporting of Schedule V drugs. Additionally, the Board of Pharmacy is required to share a quarterly report with the licensing boards of all prescribers have been granted prescriptive authority and the Office of Drug Control Policy, identifying abnormal or unusual prescribing practices. Any practitioner prescribing a benzodiazepine is required to access the database prior to writing the prescription. Any veterinarian who prescribes an opioid is also required to access the database.

Miscellaneous Provisions

The bill exempts Board of Pharmacy expenditures of grant money in relation to substance use or controlled substances from the state's general purchasing laws.

Finally, the bill clarifies that auricular acupuncture is not considered acupuncture when used in chemical dependency treatment programs. The procedure is an alternative medicine based on the theory that the ear reflects the entire body and treatment is centered on the auricle or outer portion of the ear.

CODE REFERENCE: West Virginia Code §30-3-14, §30-3A-1 through §30-3A-4, §30-4-19, §30-5-6, §30-7-11, §30-8-18, §30-14-12a, §30-36-2, §60A-2-21, §30-60A-9-4, §30-9-5 and §60A-9-5a – amended; §16-52-4 through §16-52-9 – new

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: June 7, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 299

Relating to mandatory insurance coverage for medical foods for amino acid-based formulas

This bill requires insurance providers to cover prescription metabolic formula for persons with severe protein allergic conditions or impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length and motility of the gastrointestinal tract. The bill lists four conditions that are covered. The mandatory coverage extends only to persons who are twenty years old or younger.

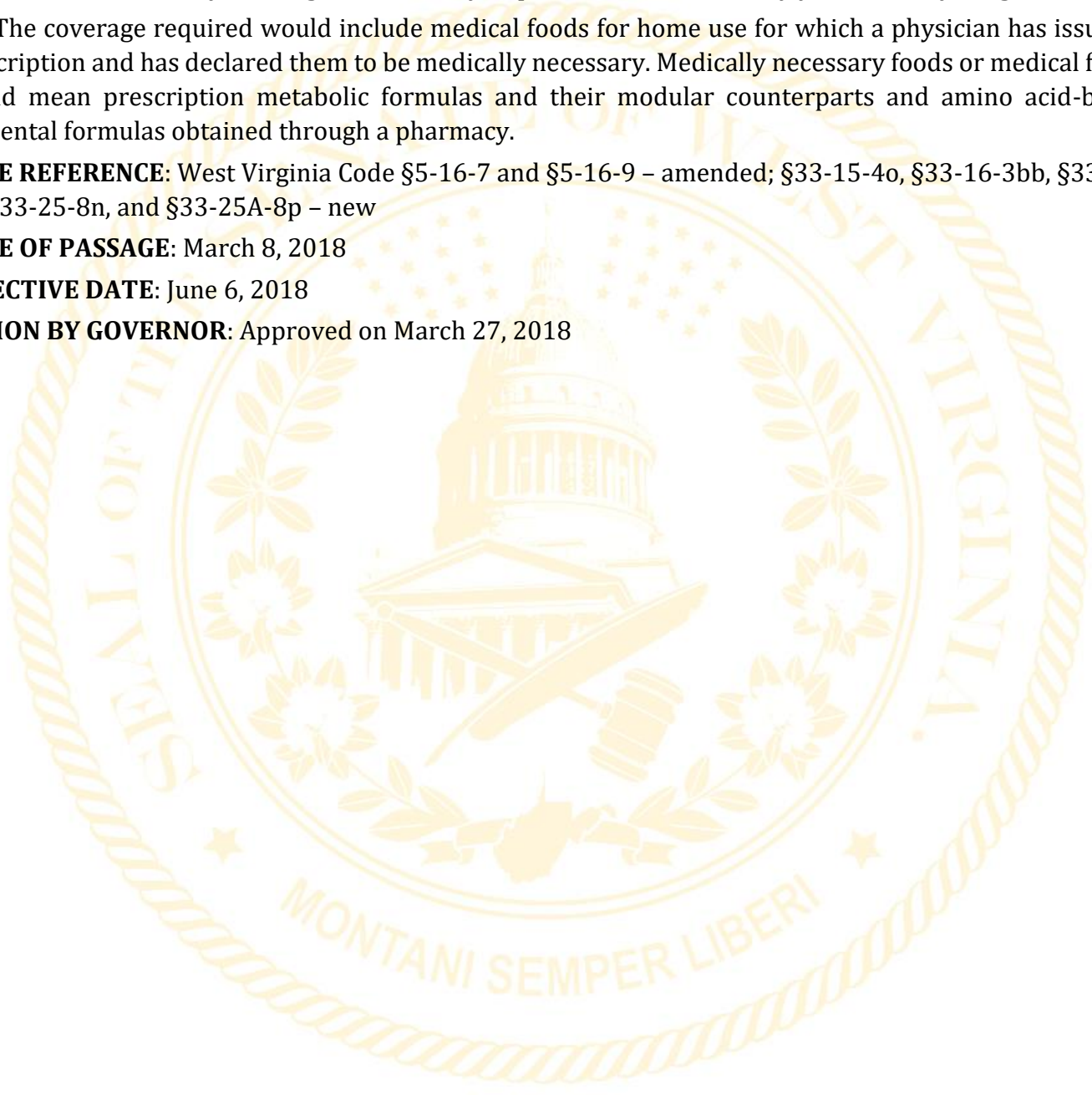
The coverage required would include medical foods for home use for which a physician has issued a prescription and has declared them to be medically necessary. Medically necessary foods or medical foods would mean prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas obtained through a pharmacy.

CODE REFERENCE: West Virginia Code §5-16-7 and §5-16-9 – amended; §33-15-4o, §33-16-3bb, §33-24-7q, §33-25-8n, and §33-25A-8p – new

DATE OF PASSAGE: March 8, 2018

EFFECTIVE DATE: June 6, 2018

ACTION BY GOVERNOR: Approved on March 27, 2018



Senate Bill 401

Requiring specified coverage in health benefit plans for treatment of substance abuse disorders.

The purpose of this bill is to require insurance carriers offering policies in this state to provide coverage for substance use recovery. The Public Employees Insurance Agency is not subject to the provisions of this bill.

The bill defines key terms. These include terms such as “insurer,” “physician or psychiatrist,” and “substance use disorder.” The bill provides that after January 1, 2019, all policies issued in this state shall provide for in and outpatient treatment for substance use disorder. There are some parameters:

- The services must be in-network – with exceptions;
- The services must be at the same level as other medical services;
- The services must be prescribed by an appropriate medical professional; and
- The services must be provided by licensed health care professional or certified substance use disorder providers.

Prior authorization and prepayment is not permitted for the first 180 days of a plan year. If there is no in-network facility, the insurer is required to provide exceptions in an out-of-network facility. If an in-network facility becomes available, the person may be transferred. Benefits are subject to concurrent or retrospective review of medical necessity.

There are required procedures for when the insurer determines that inpatient care is no longer needed. These include notice within 72 hours and the right to file for an internal expedited review which must take place within 72 hours. If the internal review is adverse to the patient, he or she may seek review by an independent utilization review organization, which also has 72 hours to make a decision. There are provisions to continue the inpatient care until all appeals are settled.

The Insurance Commissioner is granted rulemaking authority to set up a procedure for the expedited review. There are provisions and timelines for retrospective review of medical necessity for outpatient or partial hospitalization.

Finally, the bill provides that medically necessary outpatient prescription drugs to treat substance use disorder are permitted without any prior authorization. There is also a provision stating that other related or unrelated diagnoses beyond substance use disorder may not be used to reduce or deny benefits.

CODE REFERENCE: West Virginia Code §33-15-4p, §33-24-7q, §33-16-3bb, §33-25-8n, and §33-25A-8p – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 407

Licensing and approval of child care programs

This bill modifies definitions relating to licensing and approval of child care programs, child advocacy, care residential and treatment programs.

The bill removes from the definition of “certificate of registration” the ability for child care programs to self-certify compliance with state regulations because changes to the Federal Child Care Development Block Grant no longer allows for self-certification. The effect of which is that the Department of Health and Human Resources is now required to determine compliance with rules regarding their oversight.

There are also changes to the definitions of “family child care facility” and Family child care home” eliminating the provision that prohibited greater than four children under the age of 24 months from being in those types of settings. The purposes of this change is to allow children from a family group close in age – including foster care children – to share the same child care provider.

CODE REFERENCE: West Virginia Code §49-1-203 and §49-1-206 – amended

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: June 7, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 408

Licensing of nursing homes and assisted living residences

This bill would update requirements for nursing homes and assisted living residences.

It makes a number of technical corrections to the name of the department, cross references and substitutes the word “secretary” for the outdated term “director”. More substantively it allows for the Secretary to place reports online rather than requiring mailing or hand delivery to the Governor, Legislature and make it more available to the public. The information required in the reports has not been dramatically changed.

There are updates to the rulemaking section regarding assisted living residences to indicated that the rules are include a process for seeking a license, the records that are to be kept by facilities, inspection procedures and dispute resolution procedures. Portions of the code relative to denying, limiting or suspending or revoking a license have been moved to a more appropriate code section. Sections regarding dispute resolution have been rewritten for clarity and to reflect current practice.

CODE REFERENCE: West Virginia Code §16-5D-16 and §16-5D-17 – repealed; §16-5D-2 through §16-5D-13 and §16-5D-15 – amended

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 441

Relating to health care provider taxes

This bill continues the tax rate for the health care provider tax on certain acute care hospitals. This was previously known as the Medicaid Upper Payment Limit but the term was modified by 42 CFR 438.6 and is now known as Directed Payment Program.

The current tax rate is set at 75/100's of one percent on gross receipts of eligible facilities. This bill simply provides that any funds remaining after Just 30, 2018, are transferred to the Medical Services Fund. It provides that this transfer may occur on September 30 of each year for the next three years at which time it will expire unless reauthorized.

CODE REFERENCE: West Virginia Code §11-27-38 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 456

Physical Therapy Licensure Compact Act

This bill will permit the WV Board of Physical Therapy to enter into a multistate licensure compact. The Compact is an agreement by our state to cooperate with other states and be members of the Physical Therapy Compact Commission.

CODE REFERENCE: West Virginia Code §30-41-1 through §30-41-3 – new

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 465

Relating to mandated reporting of child abuse and neglect

This bill was introduced upon the recommendations of the Task Force on Prevention of Sexual Abuse of Children, which was established by W.Va. Code §49-2-8 to make recommendations for decreasing incidence of sexual abuse of children. The bill clarifies that sexual abuse and sexual assault constitute abuse of a child for reporting requirement purposes. The bill also reduces the period in which a mandated reporter must report suspected abuse or neglect from 48 to 24 hours. The bill requires mandated reporters to directly report known or suspected cases of abuse or neglect to the proper authorities, rather than to simply report the cases to a supervisor or person in charge.

Additionally, the bill removes broad reporting requirements in the current Code that apply to any person over 18, as well as certain exceptions to the time-period during which mandatory reporting must take place. The bill also removes reporting requirements applicable only to school employees as well as reporting requirements specific to conduct between students and school personnel; the more general requirements in the bill for mandatory reporting already require reporting by school personnel and reporting of conduct between school personnel and students.

CODE REFERENCE: West Virginia Code §49-2-803 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 469

Converting Addiction Treatment Pilot Program to permanent program

The purpose of this bill is to make the Addiction Treatment Pilot Program a permanent program and for it to be run by the Department of Military Affairs and Public Safety.

Currently the Department of Health and Human operates a pilot program Resources in conjunction with the Division of Corrections to provide addiction treatment. This may include medication-assisted treatment (MAT) to persons within the criminal justice system.

CODE REFERENCE: West Virginia Code §62-15A-1 through §62-15A-3 – amended

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 499

Requiring one year of certain approved postgraduate clinical training for persons with foreign medical degrees

This bill would clarify the requirements for physicians who have a degree obtained from a medical school outside of the United States. Physicians who graduate from a medical school located outside the US must successfully complete two years of graduate clinical training in an accredited program or one year of graduate clinical training if they hold an ABMS certification as a specialist.

CODE REFERENCE: West Virginia Code §30-3-10 – amended

DATE OF PASSAGE: March 8, 2018

EFFECTIVE DATE: June 6, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 510

Designating hospitals for stroke treatment

This bill amends the portion of our code which allows for hospitals to be designated as stroke centers. Currently, we have three designations, comprehensive, primary and acute stroke-ready. This bill would add thrombectomy-capable to that list. This is a new designation by the American Heart Association.

The bill requires the Department of Health and Human Resources to access a national database to house data on strokes that align with metrics set by the American Heart Association. The bill also reconfigures the advisory council to add additional hospital representation. Finally, the bill precludes the Department from inspecting hospitals in relation to their stroke designation.

CODE REFERENCE: West Virginia Code §16-5B-18 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 543

Relating to confidentiality of medical records

This bill pertains to confidentiality of mental health records. Under existing code, physical health records and mental health records are governed by two different disclosure standards. As such, physical health records and mental health records must be kept separate from one another. Moreover, under existing code mandates further disclosure requirements in addition to those provided under HIPAA.

The amendment removes a 30-day consent requirement, which is not required under federal law.

The amendment is intended to provide uniform disclosure rules with respect to physical health records and mental health records. The amendment also adopts HIPAA disclosure standards, thus, making West Virginia law conform to federal law.

CODE REFERENCE: West Virginia Code §27-3-1 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: March 7, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

Senate Bill 575

Approving additional beds for intermediate care facilities

The bill permits the creation of six 4 bed transitional intermediate care facilities. The new sites may not be within 5 miles of another behavioral health care facility. A person is required to obtain a certificate of need. Once the sixth facility is approved this exemption terminates and the moratorium goes back in effect.

The bill limits who is eligible for placement in the new facilities. Only individuals who are in more restrictive institutional settings or at risk of being institutionalized will be given a choice to move.

A monitoring committee is created to provide guidance to the transition and monitor the progress of securing the most integrating setting for each individual.

Any savings shall be reinvested into home and community based services.

CODE REFERENCE: West Virginia Code §16-2D-8 and §16-2D-9 – amended

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: June 7, 2018

ACTION OF GOVERNOR: Signed on March 27, 2018

Senate Bill 576

Relating to Patient Injury Compensation Fund

This bill provides funding for remaining unfunded liabilities of the Patient Injury Compensation Fund (PICF). The Fund was created in 2004 to compensate claimants who are unable to collect damages due to statutory caps and other reforms. However, no funding stream was established in the legislation creating the PICF. In 2016, the Legislature closed the PICF to claims filed after June 30, 2016, and provided temporary funding sources for PICF claims filed before that time, including biennial fees paid by physicians, fees paid by trauma centers, an assessment on settlements and judgments in medical malpractice actions, and filing fees for plaintiffs in medical malpractice actions.

This bill extends the time during which those temporary fees will continue to be collected to satisfy projected unfunded liabilities of the PICF, as follows: physicians are required to pay a biennial license privilege fee of \$125 until December 31, 2021 (currently, the fee would be required only until December 31, 2019); and trauma centers are assessed a \$25 fee per patient treated until December 31, 2021 (currently, the fee is to be assessed only until June 30, 2020).

The bill also provides that after December 31, 2021, the filing fee required of plaintiffs in medical malpractice actions will decrease from \$400 to \$280, and that the clerk of a circuit court will no longer deposit filing fees by plaintiffs in medical malpractice actions into the PICF after that time. The bill amends the definition of a “qualifying claim,” in the context of medical malpractice claims subject to the PICF filing fee, to clarify that claims for which a “screening certificate of merit” is not required are included in the definition, and subject to PICF filing fees. Under the statutory exhaustion requirements for medical malpractice claims, a plaintiff must obtain a “screening certificate of merit,” which includes information from a health care provider setting out the basis for the claim. If a claim is based on a well-established legal theory of liability, the screening certificate of merit is not required, and the plaintiff may simply file a statement setting for the basis of the claim.

The bill designates the plaintiff or his or her counsel as the person responsible for paying the assessment in the case of settlement. The bill also conforms language in the bill establishing when an assessment must be paid with current law language describing when a medical malpractice claim may be filed.

Finally, the bill provides that any money remaining in the PICF on June 30, 2022 will be transferred to the General Revenue Fund.

CODE REFERENCE: West Virginia Code §29-12D-1a, §59-1-11, and §59-1-28a – amended

DATE OF PASSAGE: March 8, 2018

EFFECTIVE DATE: June 6, 2018

ACTION BY GOVERNOR: Signed March 22, 2018

Senate Bill 603

Relating to proceedings for involuntary custody for examination

This bill adds licensed professional counselors to the list of mental health professionals who may examine an individual by court order for the purpose of a “probable cause” hearing for involuntary hospitalization, pending further mental hygiene proceedings. A licensed professional counselor may perform the examination if the licensed professional counselor has been authorized by a circuit court order, finding that the counselor has particularized expertise in the areas of mental health and mental hygiene or addiction.

The examination is meant to assist a court in determining whether there is probable cause to believe that the person is likely to cause serious harm to him or herself or others because of addiction or mental illness, unless hospitalized pending further proceedings.

Currently, an individual awaiting a probable cause hearing for involuntary hospitalization pending commitment proceedings may be examined by the following: a physician, psychologist, a licensed independent clinical social worker with particularized expertise in mental health, an advanced nurse practitioner with psychiatric certification and particularized expertise in mental health, and a physician assistant with particularized expertise in mental health.

Licensed professional counselors are currently required to have graduate level education, pass a professional examination, and meet other requirements of the Board of Examiners in Counseling.

CODE REFERENCE: West Virginia Code §27-5-2 and §27-5-3 – amended

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4001

Relating to eligibility and fraud requirements for public assistance

This bill would require the Department of Health and Human Resources to implement a number of provisions relative to applicants for assistance and recipients for assistance at the Department. It defines key terms. Currently, applicants for SNAP are able to seek a work requirement waiver from the federal government. Additionally, only the applicants income/assets are tested, without further verification via computer tracking database. (2018)

This bill relates to investigations, inspections, evaluations, and review conducted by the Department of Health and Human Resources to prevent fraud and abuse. It disenrolls providers who commit fraud and requiring repayment. Further, the bill authorizes the Secretary to develop a data analytics pilot program to identify potential fraud and help guide policy objectives to eliminate future fraud, and requires a report on the pilot project to the Legislature. The bill defines fraud as it relates to Medicaid, creates criminal penalties against providers for failure to keep medical records for a specific time period, authorizes a civil cause of action for fraud when a person or entity knew or reasonably should have known a claim to be false, and enlarges the statute of limitations to file health care fraud civil actions.

It defines terms relating to public assistance, and requires the Department of Health and Human Resources to implement work requirements for applicants of Supplemental Nutrition Assistance Program (SNAP). It limits recipients to 3 months of benefits in any 36-month period unless the recipient is working or participating in a work, educational, or volunteer program for at least 20 hours a week. The bill provides further exemptions to work requirements, requires discontinuance of a federal waiver in certain counties, requires a study of the impact of the SNAP work requirements in those counties where they were implemented, eliminates the federal waiver statewide within a certain time-period, and requires a report to the Legislature.

The bill further establishes work requirements, authorizing a waiver to if necessary to implement a policy that complies with federal law, and authorizes rulemaking. It requires a design or establishment of a computerized income, asset, and identity verification system for each public assistance program administered by the Department of Health and Human Resources, allows for contracting with a third-party vendor, and sets out required contract terms. The bill requires accessing information of various federal, state, and miscellaneous sources for eligibility verification, requires identity authentication as a condition to receive public assistance; requiring the department to study the feasibility of requiring photos on EBT cards, specifies procedures for case review of public assistance benefits, sets forth notice requirements and right to a hearing, requires referrals for fraud, misrepresentation, and inadequate documentation, and authorizes referrals of suspected cases of fraud for criminal prosecution. Lastly, the bill requires a report to the Governor and Legislature related to cases of fraud. It sets forth prohibitions on the use of an electronic benefit transfer card, tracks out-of-state spending of SNAP and TANF benefits, and provides a penalty for taking the identity of another person for the purpose of gaining employment.

CODE REFERENCE: West Virginia Code §9-2-6, §9-7-2, §9-7-5, and §9-7-6, and §61-3-54 – amended; §9-8-1 through §9-8-12 – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4023

Relating to the regulation of dialysis technicians

The bill permits a dialysis technician who is practicing on a temporary permit to be renewed by the Board of Examiners for Registered Professional Nurses once from the renewal date on the expiration of the original temporary permit for a period of 18 months. It also deletes the cumbersome reciprocity process. A more streamlined process is included in their legislative rule.

CODE REFERENCE: West Virginia Code §30-7C-9 – repealed; §30-7C-3 – amended

DATE OF PASSAGE: March 6, 2018

EFFECTIVE DATE: June 4, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4025

Permitting reciprocity for licensure as a pharmacy technician

This bill updates the requirements for practice as a pharmacy technician. The new provisions add a reciprocity provision that allows a technician who has practiced in another state and has a national certification and has practiced in another jurisdiction for a period of time as determined by the board.

CODE REFERENCE: West Virginia Code §30-5-11 – amended

DATE OF PASSAGE: March 6, 2018

EFFECTIVE DATE: June 4, 2018

ACTION BY GOVERNOR: Signed March 20, 2018

House Bill 4027

Creating an education permit for allopathic physician resident

This bill would require allopathic medical residents to hold a license to practice medicine beginning July 1, 2019. The license would authorize its recipient to practice medicine or surgery only within the recipient's training program.

The permit shall be valid for up to one year of post-graduate training and may be renewed if the recipient is still eligible. The Board may deny, suspend or revoke a permit based upon grounds set forth by legislative rule.

CODE REFERENCE: West Virginia Code §30-3-13 – amended; §30-3-16 – new

DATE OF PASSAGE: March 6, 2018

EFFECTIVE DATE: June 4, 2018

ACTION BY GOVERNOR: Signed March 22, 2018

House Bill 4035

Creating a legislative coalition to study and report to the Legislature on palliative care

This bill creates the State Advisory Coalition on Quality of Life to improve the quality and delivery of patient-centered and family-focused care in West Virginia. It defines terms and provides that the administrative functions of the Coalition are the responsibility of the staff assigned to the Joint Committee on Health.

The bill specifies the types of individuals whom the President of the Senate and the Speaker of the House of Delegates are to appoint to the Coalition. The co-chairs of the Joint Committee on Health are to serve as nonvoting ex-officio members of the Coalition. Membership is to be distributed among the congressional districts.

The powers and duties of the Coalition are specified. The Coalition is required to meet at least quarterly and report its findings to the Joint Committee on Health by December 31, 2018 and annually thereafter. Minimum requirements for the report are specified. The Coalition terminates on December 31, 2021, unless continued by the Legislature.

CODE REFERENCE: West Virginia Code §16-54-1 through §16-54-7 – new

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: June 7, 2018

ACTION BY GOVERNOR: Signed March 22, 2018

House Bill 4079

Promulgating administrative rules by various executive or administrative agencies of the state

This bill is known as the Miscellaneous Rules bundle which authorizes and directs the promulgation of 38 rules and repeals two rules which constitute bundle 9. Only the legislative rules directly relating to the health care industry are included in this summary.

Board of Dietitians, Licensure and Renewal Requirements, 31 CSR 1

The proposed rule provides for increases in licensing fees collected by the Board of Licensed Dietitians. For the 2016 FY, there were approximately 400 licensees. Licenses must be renewed annually. The table below outlines the current fees, the proposed fees, and the total increase:

- Application Fee: \$50, \$75, \$25
- Provisional Permit: \$50, \$75, \$25
- Annual Renewal: \$50, \$75, \$25
- License Reinstatement: \$75, \$125, \$100
- Late Renewal*: \$75*, \$125, \$50

The current language of the rule does not provide for fee amounts. The current fees assessed by the Board are outlined throughout W.Va. Code §30-35-1 et seq. The Code provides that the fees for provisional permit or renewal, application for license, and license renewal shall be \$50 or a reasonable fee established by legislative rule. The Code also provides for a reinstatement fee to renew a license which has expired, in addition to the annual renewal fee, that shall be \$25 or a reasonable fee established by legislative rule. The phrase “or a reasonable fee established by legislative rule” that is provided throughout the article authorizes the fee increases through rulemaking.

The Board asserts that there are several reasons for increasing the fees. First of all, the Board is moving offices, and its rent is increasing from \$138 per month to \$275 per month, which is a yearly expense increase of \$1,644. The Board is hoping to use an attorney from the Attorney General’s Office more frequently, which requires the Board to pay an hourly fee to the Attorney General. The Board also anticipates increases in expenses related to Board members’ travel costs, salary for an administrative assistant, training, and investigations.

The House Judiciary Committee amended the proposed rule by specifying a \$50 provisional license fee and by correcting several internal citations

Fiscal Impact: The Board asserts that the fee increases would generate an additional \$34,500 in revenue. If approved by the Legislature, the proposed fee increases would be the first increase of fees for the Board since its formation in 1997.

Hearing Aid Dealers, WV Board of Hearing Aid Dealers, 8 CSR 1

The proposed rule charges fees for administering examinations. The board has not previously charged for this activity. Fiscal Impact: \$550.

Board of Medicine, Licensure of Physician Assistants, 11 CSR 01B

This rule implements Senate Bill 1014 that was passed during this First Extraordinary Legislative Session. This bill modernized the provisions of the Physician Assistants’ Practice Act.

The word “collaborating” replaces “supervising” throughout. The powers and duties of the two licensing boards have been modified to permit a physician assistant in a collaborating arrangement with a physician the same prescriptive authority as provided to advanced practice registered nurses last session.

The requirement that a physician assistant be certified under the National Commission on Certification of Physician Assistants has been removed.

The final change would grant them global signatory authority in a manner identical to that which was given to advanced practice registered nurses last session. They can sign death certificates, order for life sustain treatment, orders for scope of treatment and DNR forms. They may also issue handicap hunting certificates and utility company forms requiring maintenance of utilities regardless of ability to pay.

Board of Medicine, Continuing Education for Physicians and Podiatrists, 11 CSR 6

The proposed rule concerns continuing education for physicians and podiatric physicians. This rule has been revised and, in some sections, reorganized, for clarity, ease of reference by licensees and applicants, and to eliminate outdated language. Consistent with other Board rules, nomenclature has been updated to replace the term “podiatrist” with “podiatric physician” throughout this rule. The proposed amendments to the rule:

- modernize and clarify the language of the existing rule;
- identify when an applicant may utilize post-graduate training to satisfy continuing education requirements;
- update the requirements for drug diversion training and best practice prescribing training to incorporate a training component on prescribing and administration of an opioid antagonist;
- clarify that three hours of Board-approved drug diversion training and best practice prescribing of controlled substances training must be completed each renewal cycle unless the renewal applicant has not prescribed, administered or dispensed controlled substances pursuant to a West Virginia license during the reporting period; (5) clarify when written documentation of successful completion of CME must be submitted to the Board by renewal, change of status, reinstatement and reactivation applicants; and
- establish protocol for Board approval of drug diversion training and best practice prescribing of controlled substances training.

The House Judiciary Committee amended the proposed rule to cite the correct authority for the proposed rule.

Board of Medicine, Licensing and Disciplinary Procedures: Physicians; Podiatrists, 11 CSR 1A

The Legislature is directing the Board to amend the rule to allow patient testimonials to be used in advertising.

Board of Optometry, Rules of the WV Board of Optometry, 14 CSR 1

The proposed rule implements the standardized criminal background check for an applicant language and incorporates a 10 year sunset date to the rule.

Board of Osteopathic Medicine, Osteopathic Physician Assistants, 24 CSR 2

The proposed rule implements Senate Bill 1014 that was passed during this First Extraordinary Legislative Session. This bill modernized the provisions of the Physician Assistants’ Practice Act. The word “collaborating” replaces “supervising” throughout. The powers and duties of the two licensing boards have been modified to provide to permit a physician assistant in a collaborating arrangement with a physician the same prescriptive authority as provided to APRNs last session.

The requirement that a physician assistant be certified under the National Commission on Certification of Physician Assistants has been removed.

The final change would grant them global signatory authority in a manner identical to that which was given to advanced practice registered nurses last session. They can sign death certificates, order for life sustain treatment, orders for scope of treatment and DNR forms. They may also issue handicap hunting certificates and utility company forms requiring maintenance of utilities regardless of ability to pay.

Board of Pharmacy, Licensure and Practice of Pharmacy, 15 CSR 1

The Board has proposed a new series, 15 CSR 14, to allow for the central filling of prescriptions. A proviso was added to subdivision 14.7.5 to permit the central filling of prescriptions. Further, some of the language from section 28 was cut from this Series, and moved to Series 14 (and then revised there) dealing with central prescription processing in the form of remote data entry and remote order review.

The House Judiciary Committee amended the proposed rule to increase the fee for licensure by reciprocity from \$125 to \$250.

Board of Pharmacy, Pharmacist Recovery Networks, 15 CSR 10

The Rules for Pharmacist Recovery Networks have not been updated for several years. The changes were made to modernize the rules. In addition, when the Pharmacy Practice Act was changed in 2013, some language pertaining to the Pharmacy Recovery Network (PRN) was deleted from code to leave the requirements fully to rulemaking.

The proposed rule extends the time a person may present to a WVPRN approved evaluator from two days to seven days.

After two unsuccessful intervention requests, the executive director is required to inform the licensee that the information will be submitted to the board for possible disciplinary action.

It clarifies that the information obtained pursuant to enrollment in this program is not public information and establishes that if the person violates the terms of the program the information will be submitted to the board.

Finally, it requires when reports are submitted to the board that they do not include personally identifiable information.

Board of Pharmacy, Immunizations Administered by Pharmacists and Pharmacy Interns, 15 CSR 12

House Bill 2518 passed this year, provides for additional rulemaking on pharmacists and pharmacy interns to provide certain immunizations.

The rule change permits a pharmacists and pharmacy interns to give the Human Papilloma Virus (HPV) vaccine to someone over age 18; and would allow for influenza and HPV vaccines to be administered to a person age 11 through 18 with written informed parental consent, a prescription from a physician, and there are no contraindications to that patient receiving that vaccine.

West Virginia Code Section §30-5-7(d) and (e) requires the advice and consent of the Board of Medicine and Board of Osteopathy for pharmacist administration of any immunizations beyond the influenza and pneumonia vaccines. The three boards have worked together to amend this rule.

Board of Pharmacy, Centralized Prescription Processing, 15 CSR 14

The Board granted a pharmacy chain a waiver to do a pilot program permitting a central filling and processing operation. Unlike retail pharmacies which dispense controlled substances directly to the patient, central fill pharmacies provide a service to retail pharmacies by preparing and packaging prescriptions for retail pharmacies to dispense to the patient. Prescription information is transmitted from

a retail pharmacy to a central fill pharmacy where the prescription is filled or refilled. The filled prescription is delivered to the retail pharmacy for pick up by the patient.

This rule would allow for central filling and processing of prescriptions by pharmacies licensed by the state, which would include non-resident pharmacies.

Board of Pharmacy, Uniform Controlled Substances Act, 15 CSR 2

21 CFR § 1301 requires wholesale drug distributors to design and operate distribution systems which disclose suspicious orders of controlled substances, and to report those suspicious orders to the DEA. Suspicious orders include orders of unusual size, orders deviating substantially from a normal pattern, and orders of unusual frequency. This rule in §15-2-4.4 contains the same provision as described above.

This rule requires a whole drug distributor to report to the board within five days:

- When a wholesale drug distributor determines to stop distributing controlled substances to a customer; and
- When a wholesale drug distributor determines not to commence distribution to a potential customer due to a concern that the customer may be involved in dispensing those substances for other than a legitimate medical purpose.

Board of Pharmacy, Registration of Pharmacy Technicians, 15 CSR 7

House Bill 2846 enacted §30-5-11a which permitted the regulation of pharmacy technician trainees.

To be eligible, an applicant must file an application and fee and have graduated from a high school, obtained a GED, be enrolled in a high school or a board-certified learning institution or training center competency-based pharmacy technician education and training program, or be employed in a pharmacy with on the job training.

Board of Pharmacy, Controlled Substance Monitoring Program, 15 CSR 8

This rule updates reporting requirements of the controlled substance monitoring program. It requires drugs of concerns to be inputted into the CSMD. A drug of concern is a drug that has a high potential for abuse. Gabapentin is added as a drug of concern. Gabapentin is approved by the Food and Drug Administration to treat epilepsy and pain related to nerve damage, called neuropathy. Gabapentin can enhance the euphoria caused by an opioid and stave off drug withdrawals. In addition, it can bypass the blocking effects of medications used for addiction treatment, enabling patients to get high while in recovery.

The rule grants access to the CSMD to:

- A dean of any medical school or his or her designee located in this state to access prescriber level data to monitor prescribing practices of faculty members, prescribers and residents enrolled in a degree program at the school where he or she serves as dean;
- A physician reviewer designated by an employer of medical providers to monitor prescriber level information of prescribing practices of physicians, advance practice registered nurses or physician assistant in their employ;
- A chief medical officer of a hospital or a physician designated by the chief executive officer of a hospital who does not have a chief medical officer, for prescribers who have admitting privileges to the hospital or prescriber level information;
- Authorized agents of OHFLAC; and
- Authorized agents of BMS.

Board of Psychologists, Fees, 17 CSR 1

This rule establishes the fee structure for licensees of the Board of Psychologists. Fees for applications for licensure, license renewal, licensure examination, and duplicate license are increasing. The Board anticipates that the fee increase will generate an additional \$38,000 per year. This is the first change in fees in 13 years.

Board of Psychologists, Requirements for Licensure as a Psychologist and/or a School Psychologist, 17 CSR 3

This rule establishes the requirements for licensure. The Board has modified this rule to accommodate changes to the Code over the last two years. The major changes include special volunteer licensure, licensure requirements for continuing education for veterans, including reference to the new Code of Ethics, updating internship, timing, and training requirements, and updating language.

Board of Psychologists, Code of Ethics, 17 CSR 6

This rule establishes the code of ethics for psychologists. The Board previously adopted the code of ethics from the American Psychological Association. Upon advice from legal counsel and others, the Board has created its own code of ethics to govern the practices of psychology in West Virginia.

Board of Veterinary Medicine, Schedule of Fees, 26 CSR 6

The proposed rule Rearranged fees to be in sequence with each profession; Removed “temporary permit” fee; Removed “animal euthanasia gas chamber inspection administrative fee” since we no longer register these facilities; Removed “change of address” fee because address changes are available online; Removed “cash” from the acceptable ways of payment; Removed “copies of public record”; Removed “WV State Police background check” fee since the licensee will be paying the fee directly to the WV State Police; Modified “duplicate license” fee so there is no longer a fee if done online; Modified “Certified animal euthanasia technician application, exam & certification fee” to include the Rules and Practice Act. This is not a fee increase since the Rules and Practice act is required and was always added in the total application fee; Modified “Inspection of a facility which employs a certified animal euthanasia technician” to only include the ones that are euthanizing; Added “veterinary inactive license fee”; Added “veterinary inactive license reactivation fee.”

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: March 9, 2018

ACTION BY GOVERNOR: Signed March 20, 2018

House Bill 4156

Establishing the qualifications of full and part time nursing school faculty members

The bill sets the requirements for faculty for nursing programs.

Full time faculty shall:

- Have a Nursing Master's degree;
- Nursing Bachelor's degree and be enrolled in a nursing master's program within 1 year of employment;
- Nursing Bachelor's degree and 15 years' experience in direct patient care
- Part-time faculty:
 - Have a Nursing Master's degree
 - Nursing Bachelor's degree and be enrolled in a nursing master's program within 1 year of employment
 - Nursing Bachelor's degree and 2 years' experience
 - If a proposed faculty member has less than 2 years teaching experience he or she is required to participate in a mentoring and orientation program.

The board may also disregard the requirements of this section if they feel a person has other qualification acceptable to the board.

Additionally, the bill deems a registered nurse program that is nationally accredited by a nursing accrediting body to be deemed accredited by the Board of Examiners for Registered Nurses. Initial accreditation of the program stays with the board.

It further provides that a practical nurse program that is nationally accredited is deemed approved by the practical nursing board. A practical nursing program that is not nationally accredited remains under the control of the practical nursing board.

CODE REFERENCE: West Virginia Code §30-7-1, §30-7-5, and §30-7A-8 – amended; §30-7-5a – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: March 10, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4175

Preventing requirement that an advanced practice registered nurse participate in a collaborative relationship to obtain payment

The bill provides that an insurance company or managed care organization may not require an advanced practice registered nurse to participate in a collaborative agreement in order to obtain payment for his or her services.

CODE REFERENCE: West Virginia Code §33-4-22 – amended

DATE OF PASSAGE: March 2, 2018

EFFECTIVE DATE: May 31, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4178

Permitting certain portions of certified nurse aide training to be provided through distance learning technologies

This bill would allow nonclinical instruction for a nurse aide to be done via distance learning. The bill requires the Office of Health Facility Licensure and Certification to approve the program.

CODE REFERENCE: West Virginia Code §16-5C-2 and §16-5C-5 – amended

DATE OF PASSAGE: March 6, 2018

EFFECTIVE DATE: June 4, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4199

Permitting a nursing home to use trained individuals to administer medication

The purpose of this bill is to allow nursing homes to allow persons who are properly trained to administer medication under the direction of a registered nurse. The provisions of the bill are permissive and no one is required to participate.

The bill repeals an article in Chapter 30 which allowed a pilot project to allow unlicensed personnel to administer medication in a nursing home setting. It is replaced with an article in Chapter 16. That article allows the practice in code.

The bill defines terms. Most notably is a definition of “approved medication assistive personnel [AMAP]”. That term is defined as a staff member meeting minimum training requirements and competency testing to allow them to administer medication. These medications may be ingested, applied or inhaled, but not injected except for prefilled insulin and insulin pens. Drugs listed on Schedule I and Schedule II are specifically exempted.

The bill allows the Office of Health Facility Licensure and Certification (OHFLAC) to establish a program for medication administration. There are provisions for exempting these persons from licensing. The bill also sets out specific instruction and training requirements, including the need to retrain every two years.

The AMAP is required to administer medication that is in its original container, make a written record, and comply with all other requirements that may be set forth in rule. There are provisions for nursing homes to monitor these programs and a provision for withdraw of authority if the AMAP is not properly performing. The circumstances of this must be documented.

The Office of Health Facility Licensure and Certification is given authority to charge a fee. Finally, the bill sets out tasks which an AMAP is precluded from doing.

CODE REFERENCE: West Virginia Code §30-7D-1 through §30-7D-13 – repealed; §16-5AA-1 and §16-5AA-10 – new

DATE OF PASSAGE: March 8, 2018

EFFECTIVE DATE: June 6, 2018

ACTION BY GOVERNOR: Vetoed on March 28, 2018

House Bill 4217

Permitting an attending physician to obtain a patient's autopsy report

This bill would allow a chief medical examiner to release to a hospital who reported a death and the attending physician who attended the patient, a copy of the autopsy and toxicology report.

CODE REFERENCE: West Virginia Code §61-12-10 – amended

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 21, 2018

House Bill 4332

Relating to home peritoneal renal dialysis

This bill pertains to renal dialysis for patients with end state renal disease. The bill exempts the sale or distribution of devices and drugs need to perform home peritoneal renal dialysis from the registration requirements for pharmacies. Before the drugs and devices may be exempted, there are required to meet certain criteria. The bill exempts cashiers in pharmacies from licensure under the pharmacy practice act.

CODE REFERENCE: West Virginia Code §30-5-22 and §30-5-29 – amended

DATE OF PASSAGE: March 3, 2018

EFFECTIVE DATE: June 1, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4336

Updating the schedule of controlled substances

This bill updates four schedules of controlled substances. The bill generally reorganizes each section by removing much of the numbering and lettering that distinguished each subdivision. The bill further adds catch-all language to the initial subsection of each schedule and removes catch-all language that is interspersed throughout each schedule. The catch-all language added to the initial subsection of each schedule would include not just the chemical substance listed but also “their isomers, esters, ethers, salts and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers and salts is possible within the specific chemical designation.” The bill adds chemical compounds to three of the schedules. Gabapentin and pregabalin are added to Schedule V. Dronabinol is added to Schedule II, and several new chemical compounds are added to Schedule I, including the chemical compound for fentanyl.

CODE REFERENCE: West Virginia Code §60A-2-204, §60A-2-206, §60A-2-210, and §60A-2-212 – new

DATE OF PASSAGE: March 9, 2018

EFFECTIVE DATE: June 7, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4392

Relating to Medicaid subrogation liens of the Department of Health and Human Resources

This bill pertains to the subrogation rights of the Department of Health and Human Resources. The bill removes restrictions on the amounts which are subject to recovery. The notice requirements have been altered and streamlined. The Secretary is given the ability to negotiate for a reduction in the lien as an incentive to get Medicaid members to prosecute third parties. All references to allocation of medical expenses have been removed. There have also been changes to the settlement portion of the law. These require DHHR consent prior to settlement by a member with a third party. Rejection by the DHHR of the settlement may result in the member seeking a judicial determination of the appropriateness of the settlement. The recipient/member has the burden of proof to demonstrate to the Court that the settlement is proper. The dollar threshold for an exemption from these provisions has been lowered from \$20,000 to \$1500. The final two provisions provide that failure to notify the DHHR makes the legal representative of the recipient/member or the third party liable to the DHHR for the full amount of their subrogation lien plus interest and sets an internal effective date of July 1, 2018.

CODE REFERENCE: West Virginia Code §9-5-11 – amended

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION OF GOVERNOR: Vetoed on March 28, 2018

House Bill 4400

Relating to the West Virginia Physicians Mutual Insurance Company

This bill amends several sections of code to allow the Physicians' Mutual Insurance Company (PMIC) to insure physicians licensed to practice in other states or to allow physicians licensed in this state to practice out of state. It further removes outdated code provisions that were either irrelevant to the current operation of the PMIC or set timeframes in 2003 and 2004 related to the creation of the PMIC that have long since passed. The bill also increases the number of directors on the PMIC's board who must be physicians licensed in this state from five to six, and it allows two additional directors to be chosen by election under the PMIC's bylaws. The bill reflects the PMIC's evolution from a state-funded insurance company for physicians in this state to a self-sustaining private insurer of physicians in this and other states.

CODE REFERENCES: West Virginia Code §33-20F-6 – repealed; §33-20F-3, §33-20F-5, and §33-20F-9 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 20, 2018

House Bill 4509

Relating to the establishment of substance abuse treatment facilities

This bill is to amend the law which passed last session allowing the Secretary of the Department of Health and Human Resources to allocate beds for substance use treatment throughout the state. It clarifies that these beds can be for recovery as well as treatment. Additionally, it allows any facility in which the beds are placed to be peer-led that follows standards of a national organization.

CODE REFERENCE: West Virginia Code §16-53-1 – amended

DATE OF PASSAGE: March 7, 2018

EFFECTIVE DATE: June 5, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4524

Establishing guidelines for the substitution of certain biological pharmaceuticals

This bill pertains a pharmacist to substitute a less expensive interchangeable product as defined and set forth in federal law for a biological product unless the prescriber specifically prescribes a brand name pharmaceutical. The bill also sets out a requirement that the pharmacists place the prescriber on notice within 5 days of the dispensing of a biological drug. This notice is required to include the specific product dispensed. The notice may be electronically sent through various methods set out in the bill, or via telephone or other means. There are exceptions to that communication.

CODE REFERENCE: West Virginia Code §30-5-12c – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

House Bill 4603

Providing immunity from civil liability to facilities and employees providing crisis stabilization

Certain non-profit behavioral health facilities and residential recovery facilities are not liable for injury related to the provision of short-term crisis stabilization and/or drug and alcohol detoxification services, substance use disorder services, drug overdose services, and/or withdrawal services. The bill only applies to nonprofit facilities that do not require payment from the individual receiving the services. The facilities will be held liable to the extent the injury was caused by gross negligence or willful or wanton misconduct of the facility.

CODE REFERENCE: West Virginia Code §55-7K-1 through §55-7K-3 – new

DATE OF PASSAGE: March 10, 2018

EFFECTIVE DATE: June 8, 2018

ACTION BY GOVERNOR: Signed March 27, 2018

2018 First Extraordinary Session

Senate Bill 1005

Amending sections of Physical Therapy Licensure Compact Act

The purpose of this bill is to amend the venue, enforcement and rulemaking sections of the Physical Therapy Licensure Compact Act (Enrolled Committee Substitute for Senate Bill 456) to conform with the provisions of the model act provided by the Physical Therapy Compact Commission to allow West Virginia to become a participating member.

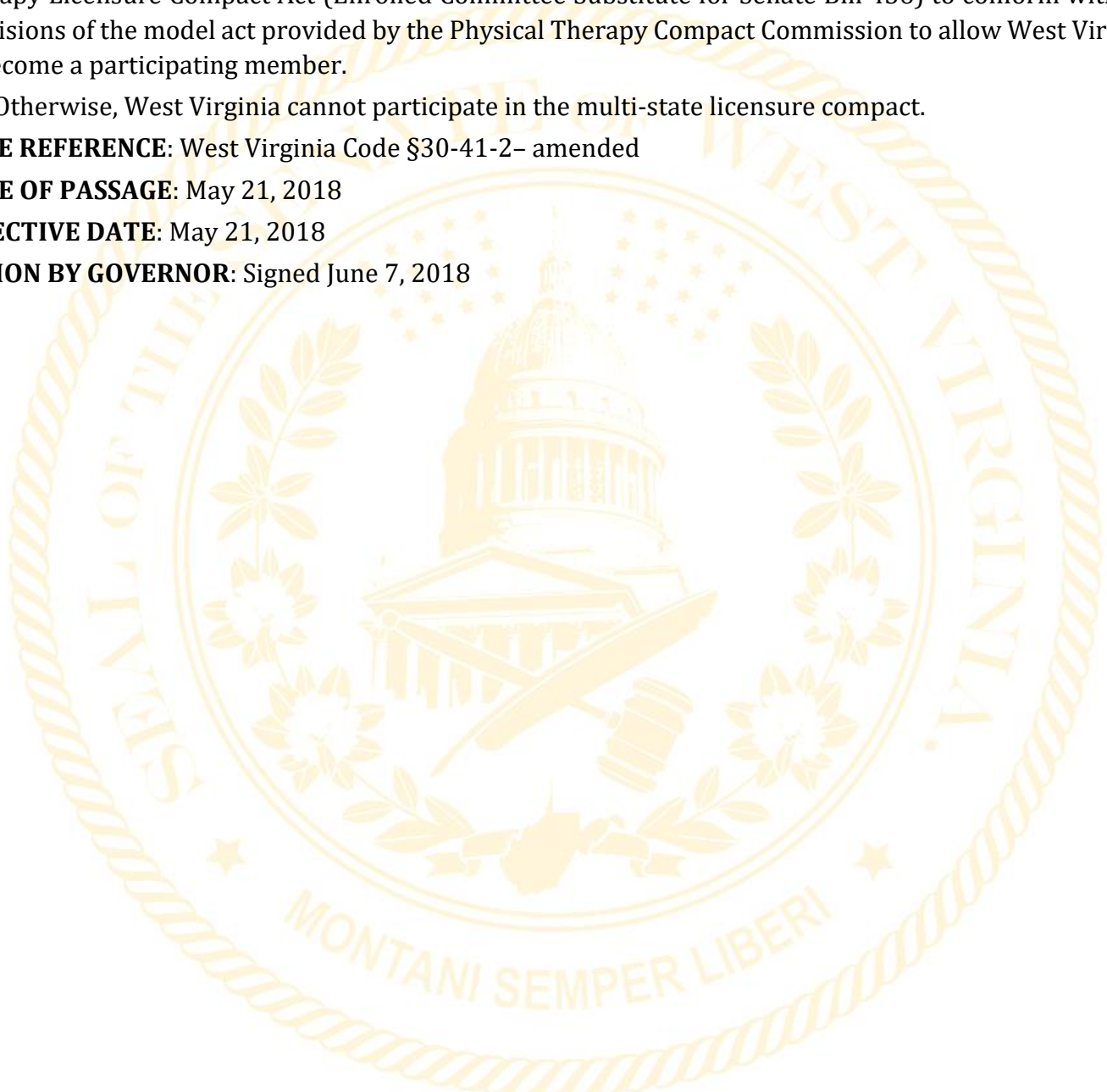
Otherwise, West Virginia cannot participate in the multi-state licensure compact.

CODE REFERENCE: West Virginia Code §30-41-2- amended

DATE OF PASSAGE: May 21, 2018

EFFECTIVE DATE: May 21, 2018

ACTION BY GOVERNOR: Signed June 7, 2018



2017 Regular Session



Senate Bill 4

Allowing licensed professionals donate time to care of indigent and needy in clinical setting

This bill would allow various health care professionals to donate their professional time in free clinics in either the clinic or in their offices. Any reimbursement received may be donated to the clinic. The bill also allow person who render services pursuant to a special volunteer license to receive continuing education hours for the performance of such volunteer services. Each discipline may receive one hour of continuing education for each hour spent up to a maximum of hours which varies by discipline.

The bill would affect: physicians; dentists; dental hygienists; pharmacists; registered professional nurses; advanced practice registered nurses; optometrists; physical therapists; psychologists; and occupational therapists.

CODE REFERENCE: West Virginia Code §30-3-10a, §30-3E-14; §30-4-15, §30-5-17, §30-7-6a, §30-8-16, §30-14-12b, §30-20-13, §30-21-17, §30-28-8a – amended; §30-1-21, §30-7-6b, §30-7A-6a, §30-16-7a – new

DATE OF PASSAGE: April 6, 2017

EFFECTIVE DATE: July 5, 2017

ACTION BY GOVERNOR: Signed April 20, 2017

Senate Bill 36

Permitting school nurses to possess and administer opioid antagonists

This bill would allow a school nurse to possess and administer an opioid antagonist on or near a school if he or she believes in good faith that a student or other individual is suffering from an adverse opioid event.

CODE REFERENCE: West Virginia Code §18-5-22d – new

DATE OF PASSAGE: April 1, 2017

EFFECTIVE DATE: June 30, 2017

ACTION BY GOVERNOR: Signed April 11, 2017

Senate Bill 125

Authorizing DHHR and Health Care Authority promulgate legislative rules

This Committee Substitute contains nine bills which constitute Bundle 5, Department of Health Human Resources. Each rule is discussed below. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health Human Resources, Expedited partner therapy, 64-103

This is a new rule made necessary by the passage of Senate Bill No. 123 during the 2016 Regular Session of the Legislature. That bill created the practice of expedited partner therapy in West Virginia. That practice allows a physician to prescribe medication for a sexually transmitted disease to both or all partners in a sexual relationship if only one of the parties is the patient of the physician.

The rulemaking authority granted to the Department of Health and Human Resources was very specific. It provides that the Secretary should list those sexually transmitted diseases which may be treated by expedited partner therapy. In rendering this list, the Secretary is required to consider recommendations from the United States Department of Health and Human Services, the Centers for Disease Control and Prevention and other nationally recognized medical authorities.

The rule as presented contains two definitions – both of which are a mirror image of the definitions contained in the code. These are “expedited partner therapy” and “health care professional”. As for the diseases, which may be listed, the Secretary has listed two sexually transmitted diseases which may be treated in this method. These are chlamydia and gonorrhea.

Department of Health Human Resources, Clinical laboratory technician and technologist licensure and certification, 64- 57

This is an amendment to existing rule of the Bureau for Public Health. The rule sets out licensing requirements for clinical laboratory technicians. The rule contains the standard General section. The only modification to this section pertains to the newly required Sunset Date. In this rule that is set for 10 years.

Throughout the rule - including the title the word “technologists” has been replaced with “scientist”. This is an update to current industry standards. Additionally, in the Definition section was amended to delete the definition of “Certified” and replace it with a definition of “Certifying Agency” which is a list of agencies which offer certification of clinical laboratory technicians. This change simply rewrites the current certification requirements. No new requirements are added.

The section pertaining to licensing requirements has been updated. Clarity has been added to ensure that persons seeking a license renewal have notified the Secretary of the successful completion of currently required continuing education requirements. Additionally, conforming amendments were made for terminology such as “scientist” and “certifying agency”. Of a more substantive nature is the addition of successful completion of a proficiency examination. Additionally, the education section has been rewritten for clarity and organization. Added to this section is the ability to allow a high school graduate with appropriate clinical training approved by the United States Department of Health and Human Services or the United State Military to apply for a license.

Finally, the rule has been renumbered to account for the changes made to the rule.

Department of Health Human Resources, Medication-assisted opioid treatment programs, 69-11

This is a new rule. It is necessary as a result of the passage of Senate Bill No. 454 during the 2016 Regular Session of the Legislature. That bill required regulation of all medication assisted treatment facilities.

This rule pertains to regulation of opioid treatment programs, more commonly referred to as methadone clinics. It contains the standard scope, authority and purpose sections. It also defines terms. It sets out the powers and duties of the state oversight authority which is designated as the Office of Health Facility Licensure and Certification. The powers and duties center on a licensing, compliance and monitoring process.

There are standard licensing requirements. These include notice and certification requirements. They also allow the oversight agency to inspect the facilities as a condition of the application. The rule also has an application process and application and inspection fees.

The rule contains conditions under which the Secretary may deny a license. These include application deficiencies, required adherence to federal and state rules and laws, the inability to conduct an inspection and failure to meet all requirements as set forth in the rule. There are notice requirements for a denial. Provisions in the rule set out a procedure for renewal and amendment of a license.

Annual inspections are allowed to maintain oversight of the facilities. There are also specific organizational and management requirements. This includes specific staffing requirements that include a program administrator, which includes his or her duties, background and educational requirements and a medical director, which includes his or her duties. There are also background and certification requirements for professional, medical and counseling staff. Various committees are set out such as peer review, advisory and admissions.

The environment requirements and operation of the facilities is provided in the rule. These include operation schedules, payment parameters, space and equipment requirements, security, infection control, community relations and emergency preparedness. There are also requirements for approval of construction and renovation and provisions for "for cause" inspections. These would result from complaints and may lead to a plan of correction. The rule also sets out a procedure for requesting waivers and variances. The circumstances for which a variance or wavier may be appropriate are set out in the rule.

The manner in which reports and records are filed, stored and open for inspection are set out. These include statistical reports and records and incident reports of adverse events. There are requirements for staff training and credentialing. These requirements include job descriptions, orientation requirements, training and confidential personnel files. There is also a requirement that all programs develop a policy for termination of staff.

Extensive risk management requirements are set forth in the rule. These include consent forms from patients, required elements which each patient is to be informed throughout his or her treatment, informing patients of all legal requirements such as HIPPA and informing patients of all patient rights and responsibilities.

The manner in which medication is to be stored, administered and accounted for through appropriate documentation is included in the rule. It requires programs to develop policies with respect to storage and management of drugs. These shall be in accordance with state and federal regulations, including DEA regulations. These policies are also to account for take-home medication and anything necessary to prevent

diversion. There are also specific requirements for administration of medications, instrument calibration, dosage ordering and medication documentation.

The rule provides for random drug screenings on a monthly basis. Drug tests are also required prior to entry into any program. Patients are to be notified at the outset of treatment that drug screenings are a necessary part of the treatment program.

Medication used by all programs is limited to that which is approved by the FDA. Dosage levels are to be discussed with patients. Levels shall be based on the clinical evaluation of a physician. Administration and level adjustments shall be set by the desired outcome for a patient. Included in the outcomes are cessation and withdrawal. The rule allows for electronic prescribing and requires full identifying information on prescriptions. Review of the Controlled Substances Monitoring Database is required upon admission and at least every 90 days. There are also requirements for the administration of Methadone. These limit it to oral form and also sets forth initial dosage limitations.

MAT programs are required under the rule to develop and maintain quality assurance and control plans. These are to account for staff education, interaction with the various review committees set forth in the rule, review of patient treatment plans, internal policy reviews, development of patient satisfactory surveys, ongoing assessments of patient outcomes, diversion and criminal activity reduction, assessments of medical related issues and a means to improve the quality of life of all patients.

There are very stringent controls on diversion that include a "Diversion Control Plan" which requires review and approval by the governing body, advisory council and peer review council. Required elements of the plan are spelled out in the rule.

The rule contains a section specific to patient rights. These include keeping the patient informed of a myriad of issues relative to the patient's treatment, the need for an individualized treatment plan, patient protection, a grievance procedure and the right to only be subjected to administrative withdrawal as a case of last resort. There are also extensive patient record keeping requirements that include maintenance and storage requirements, the right to a confidentiality, the necessity of keeping the patient records up to date, and what is to be included within the patient record. There is also a requirement to record in the patient's record all instances of patient contact. The requirements for this, including a timeframe, are set forth in the rule.

The admission process is set out with all pre-admission requirements and the criteria for admission. These requirements include a physical assessment, age requirements for admission (18 years is the minimum with the ability to make exceptions), necessary documentation, a behavioral analysis, and a list of high risk individuals who may be admitted without the need for a positive drug screen. There is a preclusion against obtaining treatment in more than one program and a requirement to be seen by a physician prior to dosing. Requirements for an interview and observation with a physician prior to admission, a review of all data on patient with the patient that includes a diagnosis of substance abuse disorder, the requirement for a recognition of voluntary maintenance treatment, the ability to enter a detoxification program and various requirements for non-admission and any exceptions to the admission policy are set out in the rule. There are also requirements for patient transfers from other programs. Transfers are allowed in-state only, out of state patients shall be treated as new admissions.

Specific preclusions regarding enrollment in multiple programs is set forth. This contains a requirement that upon enrollment programs are required to obtain a patient release and check for enrollment of all programs within a 100-mile radius. Additionally, the specific requirements for accessing the Controlled Substances Monitoring Database are also included.

The rule spells out the requirements for patient orientation. This includes notification of patient rights and responsibilities, patient grievance procedures, an explanation of services, an explanation about reports from the Controlled Substances Monitoring Database, financial obligations, program and facility familiarization, program policies, counselor identification, and a copy of all program rules.

There is a list of the services which are required to be offered by MAT programs. These include medical, counseling, vocational, educational, and recovery. There is a requirement for a physical assessment, a biopsychosocial assessment, and follow-up patient assessments. There is a list in the rule of what each patient shall receive upon admission including various agreements to submit to treatment. The rule contains procedures for educating patients regarding medication, the extent of their substance abuse disorder, and a requirement for individualized patient assessments and plans of treatment. There are also screening/drug testing requirements and extensive counseling requirements. These include educational and background requirements for counselors, matters that should be addressed during counseling, the ability to contract with counselors, caseload ratios, required number of sessions, record keeping and exceptions.

The rule sets out patient care following the initial assessment and admission. These include a post-admission assessment, a physical and psychological assessment, various health screens, drug screens, laboratory testing documentation and continued post admission testing requirements. There are also requirements for an initial plan of care. Requirements for the physical and biopsychosocial examinations are set out in the rule.

Each patient is to have an individualized plan of care. The rule provides that this is to be developed pursuant to national standards. It is required to be reviewed and, if necessary, revised every 90 days. The required elements of the plan of care are set forth in the rule. The plan is required to reflect the needs of the patient and provide for involvement of family members, if appropriate. In preparing the plan of care, the program must discuss in detail the patient's desire to remain in care and given other treatment options. There is also coordination of care agreements that are to be signed by the patient and his or her physician or counselor.

A significant portion of the rule deals with the procedures for unsupervised take home medication. Development of internal policies regarding the take-home medication is required for every program. These must adhere to federally approved guidelines and those approved by the Secretary. There is a procedure for application to the Secretary for additional authorities to be approved. There are also operational requirements for programs which allow take-home medication. Factors to be considered in making a determination as to the readiness for a patient to participate in the take-home program are set out. The list includes a number of elements surrounding the environment in which the patient lives, adherence to rules, the needs of the patient and hardship on the patient in traveling.

Other requirements for take-home include doses amounts, educational requirements for allowing the patient to participate, specified exclusions, drug screening requirements, allowances for guest dosages at nearby programs and the ability to apply for exemptions from the oversight agency.

In addition to other treatment options, there are also requirements for detoxification. The physician or physician extender shall oversee this as an option, and patients are required to be given this as an option. Detoxification requires a separate treatment plan and what must be addressed in the plan is included in the rule. There are limitations on the applicability of detoxification as an option based upon the patient's wishes, the clinical judgment of the physician or extender and drug screening requirements. Each MAT is required to develop policies surrounding detoxification treatment and the rule lists what is required to be

included. There are provisions for both short and long term detoxifications. Required counseling services for patient's in detoxification are set forth in the rule.

There are procedures for administrative withdrawal and involuntary discharge from the program. Policies for the use of this are required to be adopted by each MAT. Incidents which would result in administrative withdrawal are set forth in the rule. Likewise, there are procedures for medical withdrawal. This is a voluntary therapeutic withdrawal. The requirements for this include a schedule of dosage reduction, supportive treatment, an allowance for readmittance to the program within 30 days if a patient leaves against medical advice, continuing care following the final dose and a relapse prevention plan. All aspects of the program make specific allowances for female patients who are pregnant.

The procedures for the required drug testing are set forth in the bill. These are required to be conducted monthly. There are standards for collection and testing that include both blood and urine tests. Screening procedures are to be determined on a patient by patient basis. There is included, a list of substances which are required to be tested for in the required drug screens. There are also provisions for a breathalyzer test for possible alcohol abuse. Results are to be documented and used to determine additional treatment courses of action. There are allowances for legally prescribed substances. There are procedures for actions that are allowable upon a positive drug screen. These include from increased counseling and revocation of take-home privileges. The severity increases based upon the number of positive tests. Discharge from the program may result from a third failed drug test within the prescribed time period of the rule.

The manner in which special populations shall be dealt with are spelled out. These populations range from patients with alcohol and polysubstance abuse, behavioral health need, HIV patients, patients with chronic pain, pregnant patients and persons in the criminal justice system. Procedures relative to treatment of these types of populations are set forth in the rule.

There are specific requirements for the manner in which MAT programs may advertise.

Provisions to allow the Department to deny an application, revoke an application or suspend an application are included in the rule. Also, there is a list of reasons set forth that include fraud and illegal activity, practices that jeopardize patient safety, refusal to allow access to the oversight agency, operating a facility without the appropriate license, and failure to have the necessary personnel on site. The Secretary is given the authority to suspend revocation to allow the MAT to gain the necessary compliance. Upon denial suspension or revocation, the rule sets out what procedures must be followed by the MAT.

The final sections of the rule provide for penalties and injunctions, administrative due process and a means for an appeal and judicial review. These are standards as in other rules of this nature.

Department of Health Human Resources, Medication – assisted treatment – office based medication assisted treatment, 69-12

This is a new rule. It is necessary due to the passage of Senate Bill No. 454 during the 2016 Regular Session of the Legislature. That bill required regulation of all medication assisted treatment facilities.

This rule pertains to regulation of office based treatment, traditionally this type of treatment is suboxone. It contains the standard scope, authority and purpose sections. It also defines terms. Definitions were also set out in the statute and those definitions were not duplicated here. It sets out the powers and duties of the state oversight authority which is designated as the Office of Health Facility Licensure and Certification. The powers and duties center on a licensing, compliance and monitoring process.

There are standard registration and licensing requirements which are nearly identical to the above rule, 69 CSR 11. These include notice and certification requirements. They also allow the oversight agency to inspect the facilities as a condition of the application. The rule also has an application process and application and inspection fees.

The rule contains conditions under which the Secretary may deny registration. These include application deficiencies, required adherence to federal and state rules and laws, the inability to conduct an inspection and failure to meet all requirements as set forth in the rule. There are notice requirements for a denial. Provisions in the rule set out a procedure for renewal and amendment of a license.

Annual inspections are allowed to maintain oversight of the facilities. There are also specific organizational and management requirements. This includes specific staffing requirements that include a program administrator, which includes his or her duties, background and educational requirements and a medical director, which includes his or her duties. There are also background and certification requirements for professional, medical and counseling staff.

The environment requirements and operation of the facilities is provided in the rule. These include operation schedules, payment parameters, space and equipment requirements, security and infection control. There are also requirements for safe medication administration and provisions for “for cause” inspections. These would result from complaints and may lead to a plan of correction. The rule also sets out a procedure for requesting waivers and variances. The circumstances for which a variance or waiver may be appropriate are set out in the rule.

The manner in which reports and records are filed, stored and open for inspection are set out. These include inspection reports, statistical reports and records and incident reports of adverse events. There are requirements for staff training and credentialing. These requirements include job descriptions, orientation requirements, training and confidential personnel files. There is also a requirement that all programs develop a policy for termination of staff.

Extensive risk management requirements are set forth in the rule. These include consent forms from patients, required elements which each patient is to be informed throughout his or her treatment, informing patients of all legal requirements such as HIPPA and informing patients of all patient rights and responsibilities.

The manner in which medication is to be stored, administered and accounted for through appropriate documentation is included in the rule. It requires programs to develop policies with respect to storage and management of drugs. These shall be in accordance with state and federal regulations, including DEA regulations. These policies are also to provide for only using FDA approved medication assisted drugs and reviewing alternative treatments as they become available. There are also specific requirements for adjustment of dosages. There is also a requirement that each program have a policy about diversion and quality improvements. The rule also provides for a random call back program on a monthly basis.

The rule contains a requirement that all programs develop policies with respect to patient rights. These include certain notice requirements, fair and impartial treatment, an individualized plan of care and to be made aware of all aspects of their treatment plan. Additionally, the rule sets out requirements for establishing and maintaining patient records. This includes adherence to all state and federal record keeping requirements, confidentiality requirements, updating requirements and retention requirements. There is also a section on what is required to be maintained in a patient’s plan of care, which includes a record of significant contacts with the patient.

Admission criteria and an admission process is set forth in the rule. This includes an initial physical assessment which includes a medical history and a history of the patient's substance abuse. There is an age restriction of 18, but an allowance for a variance from this in rare occasions. There is required documentation and a requirement for an analysis of the behavioral signs of the patient which support a diagnosis of substance use disorder. All of this information is to be reviewed and considered prior to making an admission. High risk populations such as pregnant women, prisoners and former patients are given a higher priority. There is a preclusion against obtaining treatment in more than one program. There are also requirements for patient transfers from other programs. Transfers are allowed in-state only, out of state patients shall be treated as new admissions.

Specific preclusions regarding enrollment in multiple programs is set forth. This contains a requirement that upon enrollment programs are required to obtain a patient release and check for enrollment of all programs within a 100-mile radius. Additionally, the specific requirements for accessing the Controlled Substances Monitoring Database are also included.

The rule spells out the requirements for patient orientation. This includes notification of patient rights and responsibilities, patient grievance procedures, an explanation of services, an explanation about reports from the Controlled Substances Monitoring Database, financial obligations, program and facility familiarization, program policies, counselor identification and a copy of all the program rules.

There is a list of the services which are required to be offered by MAT programs. These include medical, counseling, vocational, educational and recovery. There is a requirement for a physical assessment, a biopsychosocial assessment and follow-up patient assessments. Also, the rule lists what each patient shall receive upon admission including various agreements to submit to treatment. The rule contains procedures for educating patients regarding medication, the extent of their substance abuse disorder and a requirement for individualized patient assessments and plans of treatment. There are screening/drug testing requirements and extensive counseling requirements. These include educational and background requirements for counselors, matters that should be addressed during counseling, the ability to contract with counselors, caseload ratios, required number of sessions, record keeping and exceptions.

The rule sets out patient care following the initial assessment and admission. These include a post-admission assessment, a physical and psychological assessment, various health screens, drug screens, laboratory testing documentation and continued post admission testing requirements. There are also requirements for an initial plan of care. Requirements for the physical and biopsychosocial examinations are set out in the rule.

Each patient is to have an individualized plan of care. The rule provides that this is to be developed pursuant to national standards. It is required to be reviewed and, if necessary, revised every 90 days. The required elements of the plan of care are set forth in the rule. The plan is required to reflect the needs of the patient and provide for involvement of family members, if appropriate. In preparing the plan of care, the program must discuss in detail the patient's desire to remain in care and given other treatment options. There is also coordination of care agreements that are to be signed by the patient and his or her physician or counselor.

In addition to other treatment options, there are also requirements for detoxification. The physician or physician extender shall oversee this as an option. Patients are required to be given this as an option.

There are procedures for administrative withdrawal and involuntary discharge from the program. Policies for the use of this are required to be adopted by each OBMAT. Incidents which would result in administrative withdrawal are set forth in the rule. Likewise, there are procedures for medical withdrawal.

Also, there is a voluntary therapeutic withdrawal. The requirements for this include a schedule of dosage reduction, supportive treatment, an allowance for readmittance to the program within 30 days if a patient leaves against medical advice, continuing care following the final dose and a relapse prevention plan. All aspects of the program make specific allowances for female patients who are pregnant.

The procedures for the required drug testing are set forth in the bill. These are required to be conducted monthly. There are standards for collection and testing that include both blood and urine tests. Screening procedures are to be determined on a patient by patient basis. Included is a list of substances which are required to be tested by drug screens. There are also provisions for a breathalyzer test for possible alcohol abuse. Results are to be documented and used to determine additional treatment courses of action. There are allowances for legally prescribed substances. There are procedures for actions that are allowable upon a positive drug screen. These include from increased counseling to revocation of take-home privileges. The severity increases based upon the number of positive tests. Discharge from the program may result from a third failed drug test within the prescribed time period of the rule.

The manner in which special populations shall be dealt with are spelled out. These populations range from patients with alcohol and polysubstance abuse, behavioral health need, HIV patients, patient with chronic pain, pregnant patients and persons in the criminal justice system. Procedures relative to treatment of these types of populations are set forth in the rule.

There are specific requirements for the manner in which MAT programs may advertise.

Provisions to allow the Department to deny an application, revoke an application or suspend an application are included in the rule. There is a list of reasons set forth that include fraud and illegal activity, practices that jeopardize patient safety, refusal to allow access to the oversight agency, operating a facility without the appropriate license, and failure to have the necessary personnel on site. The Secretary is given the authority to suspend revocation to allow the MAT to gain the necessary compliance. Upon denial suspension or revocation, the rule sets out what procedures must be followed by the MAT.

The final sections of the rule provide for penalties and injunctions, administrative due process and a means for an appeal and judicial review. These are standards as in other rules of this nature.

Health Care Authority, Exemption from certificate of need, 65-29

This is a new rule from the Health Care Authority. It was made necessary with the passage of House Bill No. 4365 during the 2016 Regular Session of the Legislature. That bill streamlined the Certificate of Need process in West Virginia.

The newly rewritten Certificate of Need (CON) statute provided for an exemption process that required approval from the Health Care Authority (HCA), but does not subject the exempted service to the often cumbersome CON process. Services and equipment are exempt from the process, but still require HCA approval. These are specified in statute; however, the process of gaining that authority was relegated to rulemaking. This rule details that process.

The rule contains the standard General section and defines necessary terms. It sets out the General Requirements which provide that services and charges for these services subject to an exemption approval may not be offered prior to HCA approval. There is included an Application section which provide the data elements necessary for an application. These include identifying information and information offering detail regarding the service or project for which the application applies.

The rule requires a fee of \$1000. This fee is set out in statute. The rule also provides a Review Process which the HCA must follow upon receipt of an application. These include notice, the inability of an affected

party to object, the inability of the HCA to have an administrative hearing and time frames for the approval. These time frames are set out in statute. There is also a provision for automatic approval should the HCA fail to act within the required 45 day time frame. The HCA is permitted to deny the application if the application fails to include the necessary financial disclosure as required by West Virginia Code §16-5F-1 relating to Health Care Financial Disclosure, or is incomplete pursuant to the rule.

Adverse decision regarding an approval may be appealed to the Office of Judges. This is permitted by West Virginia Code §16-2D-11(b) and the process is set out in West Virginia Code §16-2D-16. The final provision simply requires that the HCA be notified upon completion of the project.

Health Care Authority, Rural health systems grant program, 65-30

This rule is new and was made necessary with the passage of House Bill No. 4365 during the 2016 Regular Session of the Legislature. That bill simplified the Certificate of Need process at the Health Care Authority, but also made changes to the rulemaking authority of the agency by requiring previously allowable administrative rules be filed as legislative rules.

This rule sets out the procedure for filing for a grant by rural health systems with the Health Care Authority. It does not substantially alter the current practice. It defines key terms – most notable is the definition of an “underserved area”. It establishes a cap on grants and loans at \$50,000 but grants an allowance for a variance under “special circumstances”. It sets out the types of loans which may be given. These include collaborative and crisis or essential infrastructure grants and loans. The criteria for each loan is set forth in the rule.

The cycle for awarding the grants and loans are set at six (6) and twelve (12) months for collaborative grants and loans and allows crisis/essential grants and loans to be awarded at any time based upon need. The rule also establishes criteria for grants and loans which include being an underserved area and being a registered state vendor. There is an application process, an approval process and a notification process set out in the rule. Matching requirements for collaborative grants are also set out.

The manner in which a grant or loan may be awarded, a required agreement and a requirement that all expenditures be within the grant period are also set out. There is also an extensive methodology for repayment of grant funds. This sets out that reimbursement may be monthly or quarterly and allows for a schedule of payments. Provisions for a change of the grant order are set forth as well the ability to monitor grants. The Health Care Authority has the authority to request reimbursement of unspent or unreconciled funds. Procedures for closing out the grant are also included.

In addition to the agreements and repayment required for grants, there are similar agreements and repayment requirements for loans. Required provisions of the loan agreement are set out in the rule. Finally, there is a provision which allows the Health Care Authority to approve or deny grant or loan applications.

Health Care Authority, Hospital assistance grant program, 65-31

This rule is new and was made necessary with the passage of House Bill No. 4365 during the 2016 Regular Session of the Legislature. That bill simplified the Certificate of Need process at the Health Care Authority, but also made changes to the rulemaking authority of the agency by requiring previously allowable administrative rules be filed as legislative rules.

This rule sets out the procedure for filing for a grant by hospitals in West Virginia with the Health Care Authority. It does not substantially alter the current practice. It establishes a cap on grants at \$50,000 but

grants an allowance for a variance under “special circumstances”. The rule allows the Health Care Authority to give grants to “financially vulnerable” hospitals. That term is defined in the rule.

The cycle for awarding the grants are set at twelve (12) months. The rule also establishes criteria for grants and requires that a hospital meet the definition in the rule of a financially vulnerable institution. The applicant is required to be a registered state vendor. There is an application process, an approval process and a notification process set out in the rule.

The manner in which a grant may be awarded, a required agreement and a requirement that all expenditures be within the grant period are also set out. There is also an extensive methodology for repayment of grant funds. This sets out that reimbursement may be monthly or quarterly and allows for a schedule of payments. Provisions for a change of the grant order are set forth, as well as the ability to monitor grants. The Health Care Authority has the authority to request reimbursement of unspent or unreconciled funds. Procedures for closing out the grant are also included. Finally, there is a provision which allows the Health Care Authority to approve or deny grant or loan applications.

Health Care Authority, Certificate of need, 65-32

This rule sets out the procedures for filing for a Certificate of Need (CON) with the Health Care Authority (HCA). The rule is new and is needed to comply with the provisions of House Bill 4365 passed during the 2016 Regular Session of the Legislature. That bill simplified the procedure for a CON application.

The bill sets out definitions in addition to the ones which are contained in Article 2B of Chapter 16 of the Code. Requirements for obtaining a CON are set out and mirror the language in the statute. There are also requirements for an application. A list of required elements for the application are included. These include the requisite approval from the governing body, a description of the project, a timetable for implementation and various documents such as policies for patient admission/relationship to the state health plan/analysis of the relationship of the project to the existing health care system. There is also a requirement to all the Health Care Authority access to information/records/sites and facilities during the pendency of the project.

Procedures are set out for supplying the HCA with additional information during the application process, a procedure for withdrawal of an application and a procedure for the HCA to review the application. The review process includes a letter of intent from the applicant to place other parties on notice. There is also a fee – which is set out in code. The HCA is required to review the application for completeness and notice to the applicant. This notice is required to include identifying information, a description of the project and necessary deadlines for the project.

The application process includes a requirement for a public hearing in contested cases. There are extensive requirements regarding the hearing set out in the rule. These include notice requirements, a timeframe order, documentation requirements, discovery requirements, the ability to have representation, testimony, a preclusion regarding ex parte communications and a procedure for review of uncontested applications that do not require a hearing. There are also timeframe requirements for hearings and uncontested cases. The timeframes may be extended for good cause.

The criteria for issuing a CON is set forth in the rule. These include the need for the service, the potential threat to the public – if any, are there alternatives, are their similar services currently available, available alternatives to new construction, will patients have trouble obtaining the service in the absence of the CON and specific requirements for expansion of skilled nursing beds. There are also requirements for approval, denial and approval with conditions.

Adverse decisions regarding a CON application may be appealed to the Office of Judges with the Insurance Commission. There are provisions for notice of appeal, a stay pending appeal, specific requirements for notice and assignment of error and the ability for the Office of Judges to enter an order, remand or continue the matter. There is also a procedure for appeal of the order to the circuit court. This includes timelines.

The rule requires progress reports to the HCA during the pendency of a project for which a CON has been granted. The requirements for the report are set out in the rule. There is also a requirement that failure to submit a report may impact future applications. These reports may be used by the HCA to grant an extension of a CON. There is also a requirement for an application for an extension prior to expiration and for a renewal for incomplete projects.

Substantial changes to a project for which a CON has been granted are not allowed by the rule unless approved by the HCA. What constitutes a substantial change is defined as a change in service area, change of location, change in the number of beds, major medical equipment which was not listed in the application, additional health services, change in square footage or an unapproved capital expenditure. There is also a preclusion for transferability of a CON.

Once a CON has been issued the HCA is required to a substantial compliance review. The HCA is required to issue their findings within 45 days. If they find that the project is not in compliance they may withdraw the CON. They are also permitted to impose fines or seek injunctive relief. There are also provisions for allowing conditional substantial compliance pending receipt of sufficient financial data.

The rule provides for withdrawal of a CON by the HCA if they find noncompliance, substantial change in the details of the project for which the CON was issued or a material misrepresentation. An applicant may appeal a withdrawal to the Office of Judges as set forth in the rule.

As provided in the statute, the rule allows for an application to determine if any proposed new service is required to have a CON. There is a \$100 fee. The HCA has 45 days to issue an order. They are also required to publish their decision regarding reviewability on their webpage.

The final provisions of the rule provide that applications for a CON are open for public inspection. There is also a list of reviewable services which is carried over from the statute.

CODE REFERENCE: West Virginia Code §64-5-1 and §64-5-2 – amended

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: April 4, 2017

ACTION BY GOVERNOR: Signed April 20, 2017

Senate Bill 187

Providing for confidentiality of patients' medical records

This bill amends W.Va. Code §27-3-1, which pertains to confidentiality of mental health records. The bill adopts certain Health Insurance Portability and Accountability Act disclosure exceptions and eliminates a 30-day requirement which is not mandated by federal law. The amendments, thus, bring West Virginia in line with federal law.

CODE REFERENCE: West Virginia Code §27-3-1 – amended

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 6, 2017

ACTION BY GOVERNOR: Signed April 25, 2017

Senate Bill 198

Expanding Health Sciences Program to allow certain medical practitioners in underserved areas

The bill would amend the provisions of the Code relating to the Health Sciences Service Program. The purpose of this program is to provide a monetary incentive for health professional students to complete their training and provide primary care in underserved areas of the state.

The bill would add 4th year medical students who have been accepted in an emergency medical internship/residency program in the state to those eligible for the incentive.

CODE REFERENCE: West Virginia Code §18C-3-3 – amended

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: July 3, 2017

ACTION BY GOVERNOR: Signed April 18, 2017

Senate Bill 333

Requiring all DHHR-licensed facilities access WV Controlled Substances Monitoring Program Database.

This bill requires medical service providers to report overdoses that resulted from the use of illicit or prescribed medication to the database including the full legal name, address, birthdate of the person being treated, and any known ancillary evidence of the overdose. The Board of Pharmacy shall, in collaboration with the Division of Justice and Community Services and the Office of Drug Control Policy, collect overdose data.

In addition, deans of the state's medical schools or their designees are to monitor prescribing habits of their faculty members, prescribers and residents enrolled in a degree program. The bill also provides access to prescriber level data to a physician reviewer designated by an employer of medical providers to monitor prescribing practices of physicians, advance practice registered nurses or physician assistants in their employ. The bill also provides access to prescriber level information to chief medical officers of a hospital or a physician designated by the chief executive officer of a hospital who does not have a chief medical officer to monitor prescribing practices of prescribers who have admitting privileges to the hospital. Data obtained from accessing the West Virginia Controlled Substances Monitoring Program database shall be recorded in a patient's medical record maintained by a private prescriber or any inpatient facility licensed pursuant to the provisions of W.Va. Code §16.

The bill clarifies the type of information to be collected and maintained by dispensers of controlled substances regarding persons picking up prescriptions other than the patient on behalf of the patient. A licensing board is required to report back to the Board of Pharmacy review committee within thirty days of resolution of any action taken by the licensing board resulting from information provided by the Board of Pharmacy. The bill also allows the Board of Pharmacy to create a "drugs of concern" list with similar reporting requirements to scheduled drugs, but provides exemptions from the penalties contained in the law. Non-reporting would be subject to potential discipline from the appropriate licensing board.

The bill, as introduced, seeks to require all facilities licensed under the provisions of chapter sixteen to access the controlled substances monitoring program.

CODE REFERENCE: West Virginia Code §60A-9-4, §60A-9-5 and §60A-9-5a – amended; §60A-9-9 – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

Senate Bill 338

Relating to medical professional liability

This bill defines “occurrence” as used in the Medical Professional Liability Act, W. Va. Code §55-7B-1 et seq. The bill provides that actions for medical professional liability against nursing home and assisted living facilities must be commenced within one year of the date of injury. Venue for such claims lies in the county in which the facility is located. The bill provides that, if a screening certificate of merit is not available at the time a notice of claim is served upon a nursing home or assisted living facility, it must be served within one hundred eighty days of the date the health care provider receives the notice of claim. The bill addresses the tolling of the statute of limitations. Lastly, the bill provides that the amendments to the MPLA from this session apply to claims that arise or accrue on or after July 1, 2017 and contains specific severability language.

CODE REFERENCE: West Virginia Code §55-7B-2, §55-7B-4, §55-7B-6, §55-7B-10 and §55-7B-11 – amended

DATE OF PASSAGE: March 31, 2017

EFFECTIVE DATE: June 29, 2017

ACTION BY GOVERNOR: Signed April 8, 2017

Senate Bill 339

Creating Legislative Coalition on Chronic Pain Management

The bill develops a coalition of specialists to review the way in which this state regulates pain clinics and pain management pharmaceuticals. The coalition shall review the state’s chronic pain management regulations and try to strike a balance between regulation, patient needs and clinical judgement of physicians. This review would also entail a review of our statutory framework. The coalition may develop workgroups of clinical specialists with needed expertise. All recommendations are to be reported back to the Joint Committee on Health. The coalition would expire on December 31, 2020.

CODE REFERENCE: West Virginia Code §16-52-1, §16-52-2, §16-52-3, §16-52-4 and §16-52-5 – new

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 5, 2017

ACTION BY GOVERNOR: Signed April 24, 2017

Senate Bill 347

Relating to modernization of Physician Assistant Practice Act

This bill would modernize provisions of the practice act for physician assistants. It adds a second physician assistant to the make-up of the Board of Medicine.

The word “collaborating” replaces “supervising” throughout. The powers and duties of the two licensing boards have been modified to provide to permit a physician assistant in a collaborating arrangement with a physician the same prescriptive authority as provided to APRNs last session.

The requirement that a physician assistant be certified under the National Commission on Certification of Physician Assistants has been removed. It adds a physician assistant to the list of medical providers who shall be paid by an insurance company for providing medical services under their scope of practice. The final change would grant them global signatory authority in a manner identical to that which was given to advanced practice registered nurses last session. They can sign death certificates, order for life sustain treatment, orders for scope of treatment and DNR forms. They may also issue handicap hunting certificates and utility company forms requiring maintenance of utilities regardless of ability to pay.

CODE REFERENCE: West Virginia Code §16-5-19, §30-3-5, §30-3E-1, §30-3E-2, §30-3E-3, §30-3E-4, §30-3E-6, §30-3E-7, §30-3E-9, §30-3E-10, §30-3E-11, §30-3E-12, §30-3E-15, §30-3E-16, §30-3E-17, §33-15-14 – amended; §30-3E-12a – new

DATE OF PASSAGE: April 1, 2017

EFFECTIVE DATE: June 30, 2017

ACTION BY GOVERNOR: Veto – April 12, 2017

Senate Bill 360

Creating Legislative Coalition on Diabetes Management

This bill creates a coalition to provide statutory and policy solutions to diabetes management. The coalition may develop workgroups of clinical specialists with needed expertise. All recommendations are to be reported back to the Joint Committee on Health. The coalition will terminate Dec of 2020.

CODE REFERENCE: West Virginia Code §16-52-1, §16-52-2, §16-52-3, §16-52-4 and §16-52-5 – new

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 6, 2017

ACTION BY GOVERNOR: Signed April 24, 2017

Senate Bill 386

Creating WV Medical Cannabis Act

The bill establishes the medical cannabis program in West Virginia. While delayed until July 1, 2019, the program is modeled after the Pennsylvania medical marijuana program, and the three most recent states to have adopted medical marijuana. In particular, the bill has the following core components:

Administration/Oversight

The bill places the program under the authority of the Bureau of Public Health in the West Virginia Department of Health and Human Resources.

- Creates an Advisory Board to make recommendations to the Bureau
- Bureau has rule-making authority (including emergency rule-making)
- Allows Bureau to enter into agreements with other states for reciprocity of identification card

Use and Possession

Authorizes the use and possession of medical cannabis. Cannabis may be dispensed to:

- A patient who receives a certification from a practitioner and is in possession of a valid identification card issued by the bureau; and
- A caregiver who is in possession of a valid identification card issued by the bureau on behalf of a certified patient.

Form of Medical Cannabis

Subject to rules promulgated under the act, medical cannabis may only be dispensed to a patient or caregiver in the following forms:

- Pill;
- Oil;
- Topical forms, including gels, creams or ointments;
- A form medically appropriate for administration by vaporization or nebulization, excluding dry leaf or plant form until dry leaf or plant forms become acceptable under rules adopted by the bureau;
- Tincture;
- Liquid; or
- Dermal patch.

Not allowed:

- Smoke medical cannabis (dry leaf/raw)
 - Bureau may add/allow by legislative rule upon recommendation from Advisory Board
- Incorporation or selling of edibles
 - Allows patient and caregiver to incorporate into edibles to aid ingestion by the patient
- Homegrown plants

Certification/ID Card

- Utilizes the Controlled Substance Monitoring System to track everything
- Sets up system in which physician may issue certificate to patient which states that the patient has a condition or conditions which allow the use of medical cannabis
 - Required physician training for four hours
- Certificate may recommend particular form and duration
 - Certificate goes to Bureau

- Bureau issues an identification card
- Patient/Caregiver takes identification card to dispensary
- Dispensary must check monitoring system prior to dispensing to confirm certificate recommendations
 - Sold in sealed/labeled/child-resistant package
 - Include a safety insert with information
 - Must carry warning label as well
- Identification card good for one year

Amount

- 30-day supply
- Allows renewal for new 30-day supply within last week of 30-day supply

Permits

- Bureau may issue permits for the following Medical Cannabis Organizations
 - Growers – up to 10 permits (allow up to 2 locations per permit)
 - Processors – up to 10 permits
 - Dispensaries – up to 30 permits (split evenly among 3 regions)
- Dispensary may not be grower or processor
- However, grower may be a processor

Fees

- Patient identification card – \$50 processing fee (waiver for financial hardship)
- Grower & Processor
 - Initial Application Fee – \$5,000
 - Permit Fee – \$50,000
 - Renewal Fee – \$5,000
- Dispensary
 - Initial Application Fee – \$2,500
 - Permit Fee – \$10,000
 - Renewal Fee – \$2,500

Controls/Monitoring

- Utilizes an electronic tracking system for seed-to-sale monitoring
- Requires Laboratory testing by grower/processor
- Local Option
 - County may vote to prohibit operation/location in county
 - Municipality may enact zoning or ordinance prohibiting or limiting number and type of organizations

Taxes

- No Sales Tax
 - Tax on sale between grower/processor and dispensary – 10%

Medical Cannabis Program Fund

- All fees and taxes collected deposited into new fund
- Allocation as follows:
 - 55% of the revenue in the fund shall be allocated to the bureau.

- The remaining 45% of the revenue in the fund shall be allocated as follows:
 - 50% shall be allocated to the Fight Substance Abuse Fund
 - 40% shall be allocated to the Division of Justice and Community Services
 - 10% shall be allocated to Law Enforcement Professional Standards/police academy

Criminal Offenses

- Diversion of medical cannabis by practitioner
- Diversion of medical cannabis
- Retention of medical cannabis
- Diversion of medical cannabis by patient/caregiver
- Falsification of identification cards
- Adulteration of medical cannabis
- Disclosure of confidential information

Civil Penalties

- Allows civil penalties for violations
- Expressly authorizes warnings to be given for minor infractions

Research Programs

- Directs Bureau to establish and develop a research program to study impact of medical cannabis on treatment and symptom management of medical conditions
- Bureau may register academic clinical research centers for research study

CODE REFERENCE: West Virginia Code §16A-1-1, §16A-2-1, §16A-3-1 through §16A-3-5; §16A-4-1 through §16A-4-5; §16A-5-1 through §16A-5-10; §16A-6-1 through §16A-6-13; §16A-7-1 through §16A-7-6; §16A-8-1 through §16A-8-3; §16A-9-1, §16A-9-2; §16A-10-1 through §16A-10-6; §16A-11-1, §16A-11-2; §16A-12-1 through §16A-12-9; §16A-13-1 through §16A-13-8, §16A-14-1, §16A-14-2, §16A-14-3; §16A-15-1 through §16A-15-9; and §16A-16-1 – new

DATE OF PASSAGE: April 6, 2017

EFFECTIVE DATE: July 5, 2017; However, the full implementation (e.g. issuance of identification cards) is delayed until July 1, 2019.

ACTION BY GOVERNOR: Signed April 19, 2017

Senate Bill 398

Creating Emergency Volunteer Health Practitioners Act

This bill sets up the volunteer health practitioners act. It creates a registration system for health care practitioners who want to volunteer their time and service during states of emergency. This law was approved in 2006 by the National Conference of Commissioners on Uniform State Laws.

This uniform law was prompted by the difficulties during the 2005 hurricane season on the gulf coast. The act calls for the creation of a registration system which out-of-state practitioners may use either before or during a disaster. The system may coincide with existing federal/state systems. It grants the Governor the authority to regulate volunteer health practitioners during states of emergencies. It provides for a registration system to be operated by a disaster relief organization, a licensing board or a governmental entity. The designation of who would operate the registration system is given to the Governor. Health care practitioners who are properly registered may practice in this state during states of emergency without the need for an additional license. The health care practitioner must be in good standing in his or home state. There are specific exclusions for credentialing and privileging. There are also limitations of liability unless the act is intentional or willful misconduct. Volunteers are also granted workers compensation coverage for death or injuries that occur while volunteering. Specific limitations in the bill require the volunteer adhere to his or her scope of practice. The State Health Officer is given the authority to modify or restrict the services provided. The host entity as defined in the bill as the entity which relies upon the volunteer services, may also restrict the volunteer services.

The DHHR is also given the power to incorporate the volunteers into and Emergency Management Assistance Compact in conjunction with an emergency. The Secretary of the Department of Health and Human Resources is given rulemaking authority.

CODE REFERENCE: West Virginia Code §29-30-1 through §29-30-11 – new

DATE OF PASSAGE: April 5, 2017

EFFECTIVE DATE: July 4, 2017

ACTION BY GOVERNOR: Signed April 18, 2017

Senate Bill 402

Relating to covenants not to compete between physicians and hospitals

This bill addresses covenants not to compete between hospitals and physicians in employment contracts. The bill limits such covenants not to compete to thirty road miles and one year in duration. The bill provides that a covenant not to compete is void and unenforceable upon expiration of the contract or the termination of employment by the employer. If the termination of the employment is at the physician's option, a covenant remains valid.

There are provisions in the bill which provide that unless the contract states otherwise, other provisions may remain enforceable. These include:

- Taking of property, patient lists or records;
- Repayment for loans, relocation expenses, signing bonuses, inducement to locate in a specific area and recruiting education or training expenses;
- Nondisclosure about trade secrets;
- Non-solicitation provisions with respect to patients and employees;
- Liquidated damages; and,
- Any other provision not in violation of state law.

There is also a provision that states that the provisions of the bill do not apply to instances when a physician has sold his or her practice to his or her employer and to contracts between physicians who are shareholder's owners, partner, members or directors of a health care practice. The provisions of the bill are effective after July 1, 2017.

CODE REFERENCE: West Virginia Code §47-11E-1 through §47-11E-5 – new

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 6, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

Senate Bill 486

Relating to health care provider taxes

The bill extends for another year the health care provider tax imposed upon eligible acute care hospitals for the purposes of raising additional revenues to reimburse those hospitals for certain medical services at a higher rate than otherwise authorized by Medicaid, all under the federal matching Upper Payment Limit program. The Legislature has adjusted the rate of this tax annually through its amendment and reenactment of this section of code each year since 2011. This year, the rate is changed from .74% of the gross receipts received or receivable by eligible acute care hospitals to .75%.

CODE REFERENCE: West Virginia Code §11-27-38 – amended

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 1, 2017

ACTION BY GOVERNOR: Signed April 25, 2017

Senate Bill 497

Relating to liability for health care providers who provide services at school athletic events.

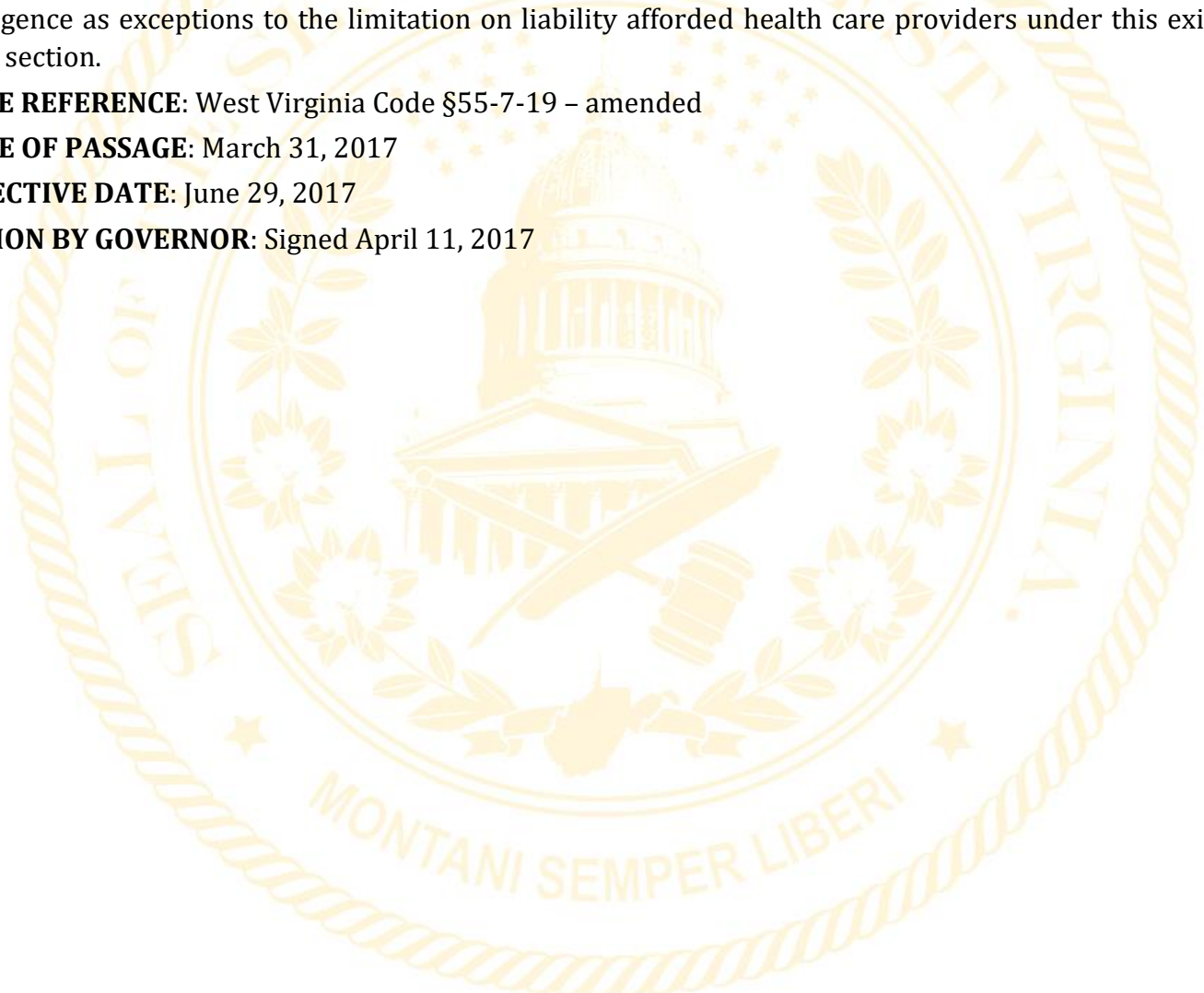
This bill revises current code, which addresses the liability for physicians who render services at school athletic events, and extends the liability protections to all licensed, certified or registered health care providers whether licensed or certified in West Virginia or another state. The bill removes the reference to physicians “acting in the capacity of a volunteer team physician” and further removes the requirement that a health care provider agree to provide emergency care or treatment prior to the athletic event such that any health care provider in attendance is afforded the immunity provided under this section. The bill also strikes the limitation on liability tied to the limits of an applicable professional liability insurance policy and the requirement that the care or treatment was rendered in accordance with the applicable standard of care under W. Va. Code §55-7B-3. The bill adds willful misconduct to gross negligence as exceptions to the limitation on liability afforded health care providers under this existing code section.

CODE REFERENCE: West Virginia Code §55-7-19 – amended

DATE OF PASSAGE: March 31, 2017

EFFECTIVE DATE: June 29, 2017

ACTION BY GOVERNOR: Signed April 11, 2017



Senate Bill 522

Relating to pharmacy audits

The bill creates a new article, called the Pharmacy Audit Integrity Act, in W Va. Code Chapter 33, Insurance. The new article applies to any audit of the records of a pharmacy of the sale and dispensing of prescription or nonproprietary drugs that is conducted by a managed care company, third-party payer, pharmacy benefits manager or an entity that represents an entity, (defined as a “covered entity”), that provides pharmacy benefits under a health insurance policy pursuant to a contract administered by a pharmacy benefits manager.

The bill defines terms and establishes procedures that must be followed when conducting a pharmacy audit. It limits the days on which an audit may take place and provides for a 14 day written notice prior to an audit being conducted. The bill limits the age and number of prescriptions that may be audited and also sets forth the type of documents the pharmacy may use to validate its records and claims. The bill provides that the auditing entity must provide the pharmacy with a written preliminary audit report 60 calendar days after completion of the audit. Upon receiving the audit report, the pharmacy is allowed 30 days to respond. A final audit report must be issued no later than 90 days after completion of the audit and shall consider and address any responses of the pharmacy to the preliminary audit report.

If an identified discrepancy in a pharmacy audit exceeds \$25,000, future payments to the pharmacy in excess of \$25,000 could be withheld pending adjudication of an appeal. A pharmacy may appeal a final audit. The article is not applicable to an investigative audit of pharmacy records when fraud, waste or abuse or other intentional misconduct is indicated or when other investigative methods indicate that the pharmacy is engaged in criminal acts.

The bill also requires a pharmacy benefits manager or auditing entity to register with the Insurance Commissioner. However, insurers and other entities already licensed by the Insurance Commissioner that want to conduct audits do not have to register separately. Also, the Insurance Commissioner is authorized to propose legislative rules necessary to effectuate this article.

CODE REFERENCE: West Virginia Code §33-51-1 through §33-51-8 – new

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: July 3, 2017

ACTION BY GOVERNOR: Signed April 20, 2017

House Bill 2002

Relating to parental notification of abortions performed on unemancipated minors

This bill concerns parental notification prior to an abortion being performed upon and unemancipated minor. The bill requires at least 48 hours notice to a parent before an abortion may be performed and it eliminates the physician's ability to waive parental notification.

CODE REFERENCE: West Virginia Code §16-2F-1, §16-2F-2, §16-2F-3, §16-2F-4, §16-2F-5, §16-2F-6 and §16-2F-8 – amended

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2119

Repealing West Virginia Health Benefit Exchange Act

This bill repeals the West Virginia Health Benefit Exchange Act. This act created the state's Health Benefit Exchange within the Offices of the Insurance Commissioner in 2011.

The Exchange has never been operational.

CODE REFERENCE: West Virginia Code §33-16G-1 through §33-16G-9 – repealed

DATE OF PASSAGE: April 5, 2017

EFFECTIVE DATE: July 4, 2017

ACTION BY GOVERNOR: Signed April 21, 2017

House Bill 2219

Authorizing miscellaneous boards and agencies to promulgate legislative rules

This bill authorizes forty-eight rules and directs the Board of Pharmacy to amend a current legislative rule. It contains a total of forty-nine rules which constitutes Bundle 9, Miscellaneous Boards and Agencies. Only the legislative rules directly relating to the health care industry are included in this summary.

Board of Examiners in Counseling, Licensed Professional Counselor Fees, 27-02

The rule significantly increases several fees charged by the Board. In addition to fee increases, the rule changes licensing renewal from a biennial cycle to an annual renewal cycle.

The rule also creates two new licensing fees. It creates a \$72.50 fee for retirement status application and renewal. It also creates a \$25 fee for certification of supervised clinical experience endorsement.

Board of Examiners in Counseling, Licensed Professional Counselor License Renewal and Continuing Professional Education Requirements, 27-03

The primary changes in the rule transfer licensing renewal from a biennial cycle to an annual cycle.

The rule also changes procedures related to reporting continuing education requirements. Although license renewal is being changed to an annual cycle, continuing education reporting is kept on a biennial reporting cycle.

The rule also establishes a new guideline for the approval of continuing education providers. The rule provides that an approved provider who does not pay a fee to re-certify within 30 days of notice forfeits all rights and privileges of an approved provider.

Board of Examiners in Counseling, Marriage and Family Therapist Fees, 27-09

The rule significantly increases several fees charged by the Board. In addition to fee increases, the rule changes licensing renewal from a biennial cycle to an annual renewal cycle.

The rule also creates two new licensing fees. It creates a \$72.50 fee for retirement status application and renewal. It also creates a \$25 fee for certification of supervised clinical experience endorsement.

Board of Examiners in Counseling, Marriage and Family Therapist License Renewal and Continuing Professional Education Requirements, 27-10

The primary changes in the rule are done to transfer licensing renewal from a biennial cycle to an annual cycle.

The rule also changes procedures related to reporting continuing education requirements. Although license renewal is being changed to an annual cycle, continuing education reporting is kept on a biennial reporting cycle.

The rule also establishes a new guideline for the approval of continuing education providers. The rule provides that an approved provider who does not pay a fee to re-certify within 30 days of notice forfeits all rights and privileges of an approved provider.

Board of Dentistry, Rule for the West Virginia Board of Dentistry, 5-01

This rule authorizes criminal background checks for applicants and incorporates a sunset date to the rule. It also adds a new subsection related to teaching permits with U.S. specialty training.

Board of Medicine, Licensing and Disciplinary Procedures: Physicians and; Podiatrists, 11-01A

The rule permits physicians to prescribe certain drugs to treat binge eating disorder; authorizes criminal background checks for applicants and incorporates a sunset date to the rule. The rule is also modernized, reorganized and consolidated.

Board of Medicine, Licensure, Disciplinary and Complaint Procedures; Continuing Education for Physician Assistants, 11-01b

The rule authorizes criminal background checks for applicants and incorporates a sunset date to the rule.

Board of Medicine, Dispensing of Legend Drugs by Practitioners, 11-05

This rule modernizes, reorganizes and consolidates the regulation of physicians who dispense prescription drugs.

Board of Optometry, Continuing Education, 14-10

This rule clarifies continuing education requirements for optometrists. The continuing education requirements for drug diversion training were confusing licensees on how many hours need to be obtained.

Board of Osteopathic Medicine, Licensing Procedures for Osteopathic Physicians, 24-01

The rule authorizes criminal background checks for applicants and incorporates a sunset date to the rule. It also adds a \$125 assessment against physicians to provide funding to the Patient Injury Compensation Fund.

Board of Osteopathic Medicine, Licensing Procedures for Osteopathic Physician Assistants, 24-02

The rule authorizes criminal background checks for applicants and incorporates a sunset date to the rule.

Board of Pharmacy, Licensure and Practice of Pharmacy, 15-01

The rule permits pharmacists to prescribe certain drugs to treat binge eating disorder; authorizes criminal background checks for applicants and renewals; incorporates a sunset date to the rule; permits a person to designate a location to obtain a prescription; and removes outdated language concerning official prescription paper.

Board of Pharmacy, Licensure and Practice of Pharmacy, 15-06

The rule updates mail-order pharmacy definitions and requires a mail order pharmacist to be licensed in this state, if providing product to this state.

The 2017 Legislature during the Regular Session directed the Board of Pharmacy to amend the below legislative rule.

Board of Pharmacy, Registration of Pharmacy Technicians, 15-07

The Legislature directed the Board of Pharmacy to amend and promulgate the current legislative rule by adding a 10-year sunset provision and a provision allowing a person who is currently enrolled in a high school competency based pharmacy technician education and training program to be a pharmacy technician trainee. The provisions are in an agency approved rule which was filed with the Secretary of State on March 24, 2017.

Board of Pharmacy, Controlled Substances Monitoring, 15-08

The rule: updates reporting requirements of the controlled substance monitoring program; requires opioid antagonists to be inputted into the database; requires drugs to be inputted into the database on the date sold; removes the exemption for distributing less than 20 controlled substance prescriptions; and reduces the amount of time to change inaccurate data from 14 days to 7 days.

WV Board of Physical Therapy, Fees for Physical Therapist and Physical Therapist Assistant, 16-04

The rule change eliminates a \$25 fee for online license verification. A license verification done in the Board's office continues to carry a \$25 fee. Therefore, the change reduces expenses to licensees.

Board of Registered Professional Nurses, Requirements for Registration and Licensure and Conduct Constituting Professional Misconduct, 19-03

The rule authorizes criminal background checks for applicants; incorporates a sunset date to the rule; and reduces a temporary permit from 180 days to 90 days to conform to the statute. It also states that a licensee whose license has been summarily suspended is entitled to a hearing.

Board of Registered Professional Nurses, Limited Prescriptive Authority for Nurses in Advanced Practice, 19-08

The rule updates the prescriptive authority of advanced practice registered nurses in compliance with statutory amendments. Previous prescriptive prohibitions have been removed and prescriptive authority, without a collaborative agreement, is provided to advanced practice registered nurses working within a collaborative relationship for 3 years.

Board of Social Work Examiners, Continuing Education, 25-05

The changes to rule were necessitated by statutory changes which require each person licensed to practice social work by the Board to complete two hours of continuing education on mental health conditions common to veterans and family members of veterans. The rule also adds an additional hour of ethics education and clarifies the requirements for earning credits online. The rule also adds flexibility in continuing education course offerings by permitting a provider to provide a majority of its classes to the outside community as opposed to all of its classes.

Board of Examiners of Speech-Language Pathology and Audiology, Licensure of Speech-Language Pathology and Audiology, 29-01

The amendments to the rule deal primarily with the Postgraduate Professional Experience (PPE) requirement for licensure of speech-language pathologists and audiologists. The PPE must consist of nine months of full-time employment (30 hours per week) or part-time employment over a longer time-period.

The rule also alters the educational requirement for a provisional license; provides that the purpose of the PPE is to permit a provisional licensee to practice speech-language pathology while working under the supervision of a person fully licensed by the board in the area in which licensure is sought; adds a requirement to supervise applicants during the PPE; eliminates the option for a supervisor to conduct several duties by correspondence; and provides that the supervisor's role throughout the PPE can be considered that of a mentor and shall include mentoring the provisional licensee in all aspects of the professional employment.

Board of Veterinary Medicine, Standards of Practice, 26-04

The rule updates the standards of practice and professional conduct of veterinarians. It sets forth practice standards for: prescriptions; lab services; X-rays; surgery, dental Services, anesthesia; and record-keeping.

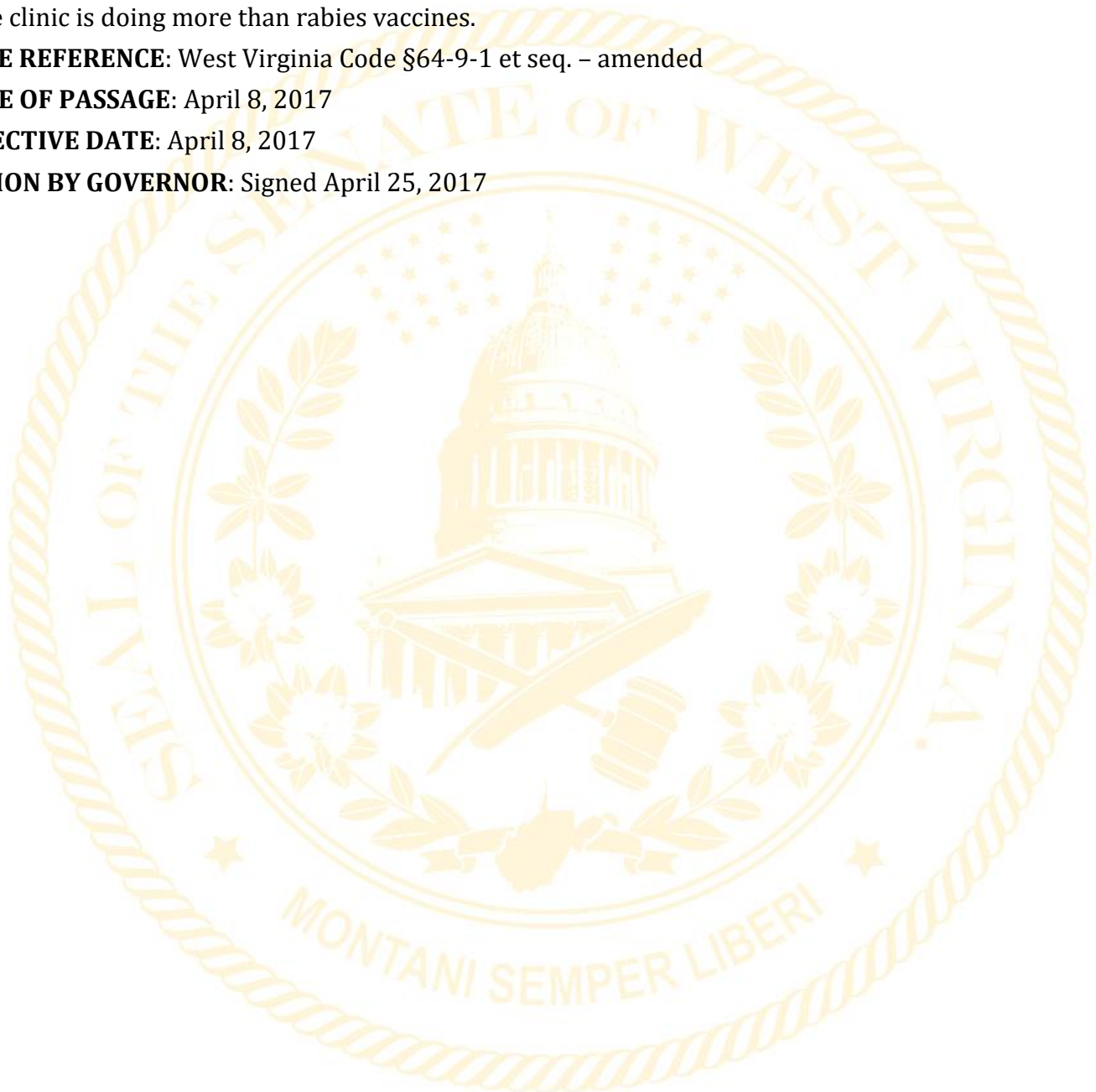
It also: sets forth standards and times for facility inspections and registrations; sets forth the requirements of a veterinarian in charge; and permits immunization clinics, which must be staffed by a vet, if the clinic is doing more than rabies vaccines.

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: April 8, 2017

ACTION BY GOVERNOR: Signed April 25, 2017



House Bill 2300

Regulating step therapy protocols

This bill would require a procedure for exception from a prescription drug step therapy plan. The bill requires the procedure to be easily accessible on a health plans website. There are conditions for granting an exception. These include: A required drug is contraindicated; The required drug is expected to be ineffective based upon the patient's history; Prior use of the drug with no effect; The drug is not medically appropriate; and the patient is stable on a current prescription. This section may not prevent a health plan from requiring the use of a generic equivalent or keep a provider from prescribing a drug he or she feels is medically appropriate.

CODE REFERENCE: West Virginia Code §33-15-4o, §33-16-3aa, §33-24-7p, §33-25-8m and §33-25A-8o – new

DATE OF PASSAGE: March 21, 2017

EFFECTIVE DATE: June 19, 2017

ACTION BY GOVERNOR: Signed March 30, 2017

House Bill 2301

Relating to direct primary care

This bill would allow the practice for certain medical professionals of direct primary care. This has been a pilot project for some years. The pilot project expired. The bill repeals the language authorizing a pilot project in Chapter 16 and moves this practice into Chapter 30. It allows for payment for direct primary care outside of an insurance plan, Medicare or Medicaid. If there is a direct payment agreement, it preclude the health care provider from billing for third party reimbursement. The bill specifically provides that these types of arrangements are not considered insurance. The agreements are to be in writing and signed by the parties. There is also the requirement for 30 days notice prior to termination. It requires that the scope of the agreement be specified and state the duration of the agreement. The disciplines which may participate in direct primary care are: 1. Physicians; 2. Optometrist; 3. Chiropractors; 4. Dentists and 5. Nurses. The licensing boards of each of these disciplines is granted rulemaking authority to effectuate the provisions of the bill. Violations of these provisions are considered unprofessional conduct.

CODE REFERENCE: §16-2J-1 through §16-2J-9 – repealed; §30-3F-1 through §30-3F-5 – new

DATE OF PASSAGE: March 15, 2017

EFFECTIVE DATE: June 13, 2017

ACTION BY GOVERNOR: Signed March 23, 2017

House Bill 2359

Relating to offenses and penalties for practicing osteopathic medicine without a license.

This bill authorizes the Board of Medicine and the Board of Osteopathic Medicine to share duties, functions and staff where appropriate.

The bill also provides that any person who practices medicine without a license is guilty of a felony and, upon conviction, is subject to a fine up to \$10,000 or imprisonment in a state correctional facility for one to five years, or both. The bill makes the penalty for osteopathic physicians the same as that for allopathic physicians.

CODE REFERENCE: West Virginia Code §30-14-12 – amended; §30-3-18 and §30-14-16 – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2428

Establishing additional substance abuse treatment facilities

This bill creates a special revenue account known as the Ryan Brown Addiction and Recovery Fund. This fund will be funded by the proceeds of litigation in Boone County, West Virginia.

The purpose of the fund is to create substance abuse beds through the state to treat persons suffering from substance abuse. The fund is to be administered by the Secretary of the Department of Health and Human Resources. The bill sets forth criteria for the Secretary to consider in placing these beds. Beds are to be placed by July 1, 2018.

CODE REFERENCE: West Virginia Code §16-53-1 – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: April 8, 2017

ACTION BY GOVERNOR: Signed April 25, 2017

House Bill 2431

Allowing influenza immunizations to be offered to patients and residents of specified facilities

This bill requires influenza immunizations to be offered to hospital patients, 65 years of age or older, on a voluntary basis based upon recommendations of the Center for Disease Control.

CODE REFERENCE: West Virginia Code §16-3-4a – new

DATE OF PASSAGE: March 15, 2017

EFFECTIVE DATE: June 13, 2017

ACTION BY GOVERNOR: Signed April 24, 2017

House Bill 2459

Relating to regulation of health care and the certificate of need process

This bill relates to the regulation of health care and modifies several provisions of code related to the Certificate of Need process.

The bill does the following things:

- Repeals redundant code section relative to neonatal abstinence facilities;
- Repeals health care facility financial disclosure;
- Repeals uniform system of financial reporting;
- Repealing information gathering and coordination advisory group;
- Updates the certificate of need process;
- Places certificate of need under Secretary of Department of Health and Human Resources;
- Adds exemptions to certificate of need and clarifies exemptions;
- Modifies computed technology exemption from certificate of need;
- Clarifies skilled nursing facility exemption for counties with no skilled nursing facility;
- Allows skilled nursing facility bed transfers;
- Requires skilled nursing facility beds retain identical certification status;
- Clarifies appeals process;
- Removes autonomy of Health Care Authority;
- Placing Health Care Authority under direct supervision of Secretary of the Department of Health and Human Resources;
- Repeals unnecessary code sections made unnecessary with transfer to Department of Health and Human Resources;
- Eliminates powers related to insurance policies and health organizations;
- Modifies health care provider tax relative to rate review;
- Eliminates public disclosure;
- Eliminates granting authority;
- Eliminates unnecessary penalties;
- Eliminates unnecessary severability section;
- Eliminates three full time board members;
- Replaces existing board with a five member board;
- Provides for appointment of board members – setting out qualifications of board members, terms of offices, filling of vacancies and oath for board members, providing for payment of board member expenses, providing for appointment of a chairman, setting out meeting requirements
- Creating the position of Executive Director – setting out power and duties of the Executive Director and setting compensation for the Executive Director
- Eliminates certain powers of the Health Care Authority;
- Eliminates hospital and health care facility assessments;
- Updates authority power relative to cooperative agreements; Provides for transfer of necessary duties of Health Care Authority to Department of Health and Human Resources;
- Requires a transition plan and sets forth necessary elements of transition plan;
- Allows transfer of West Virginia Health Information Network to private entity;
- Grants access to West Virginia Health Information Network to Secretary of Department of Health and Human Resources;

- Provides for transfer of encumbered amounts of West Virginia Health Information Network to private entity upon transfer date;
- Provides for administrative penalties for nurses overtime be paid into the general revenue fund;
- Eliminates discretionary spending of Health Care Authority for amounts from penalties for violation of the nurse overtime act;
- Substitutes executive director of Health Care Authority or Secretary of Department of Health and Human Resources for chair of Health Care Authority in various code sections;
- Transfers authority of Health Care Authority regarding uninsured small group health benefit plans to the Insurance Commission;
- Eliminates archaic revolving loan and grant fund; making conforming amendments;
- Sets effective dates for the bill and its provisions.

CODE REFERENCE: West Virginia Code §16-2D-5f, §16-5F-1 through §16-5F-7, §16-29B-6, §16-29B-7, §16-29B-9, §16-29B-10, §16-29B-11, §16-29B-17, §16-29B-18, §16-29B-22, §16-29B-23, §16-29B-24, §16-29B-25, §16-25B-27, and §16-29B-29, §16-29I-1, and §16-29I-10 – repealed; §5F-1-3a §6-7-2a, §9-4C-7, §9-4C-8, §11-27-9, §11-27-11, §16-2D-2, §16-2D-3, §16-2D-4, §16-2D-5, §16-2D-8, §16-2D-9, §16-2D-10, §16-2D-11, §16-2D-13, §16-2D-15 and §16-2D-16, §16-5B-17, §16-29B-2, §16-29B-3, §16-29B-5, §16-29B-8, §16-29B-12, §16-29B-26 and §16-29B-28, §16-29G-4, §21-5F-4, §33-4A-1 through §33-4A-7, and §33-16D-16 – amended; §16-29B-5a – new

DATE OF PASSAGE: April 5, 2017

EFFECTIVE DATE: July 4, 2017

ACTION BY GOVERNOR: Signed April 25, 2017

House Bill 2486

Providing that when a party's health condition is at issue in a civil action, medical records and releases for medical information may be requested and required without court order

This bill amends W. Va. Code §33-6F-1 by adding thereto a new subsection, designated subsection (c). Under this new subsection, medical records and medical billing records obtained by insurers in connection with insurance claims or civil litigation must be confidentially maintained by insurers in accordance with state and federal law, including the provisions of Title 114, Series 57 of the Code of State Rules. Under the new subsection, no additional restrictions or conditions may be imposed that contradict or are inconsistent with any applicable policy of insurance or the performance of insurance functions permitted or authorized by state and federal law.

The bill requires the Insurance Commissioner to review the current provisions of Title 114, Series 57 of the Code of State Rules and, if determined necessary, shall propose new rules or modify existing rules by December 31, 2017 to address four specific areas:

- The circumstances under which an insurance company may disclose medical records and medical billing records to other persons or entities;
- The circumstances under which personal identifying information of a person must be redacted before that person's medical records or medical billing records may be disclosed to other persons or entities;
- The steps an insurance company is required to undertake before medical records or medical billing records are disclosed to other persons or entities to assure that any person or entity to which an insurance company is disclosing a person's medical records or medical billing records will be using such records only for purposes permitted by law; and,
- The implementation of the requirement that the insurance company has processes or procedures in place to prevent the unauthorized access by its own employees to a person's confidential medical records or medical billing records.

CODE REFERENCE: West Virginia Code §33-6F-1 – amended

DATE OF PASSAGE: March 31, 2017

EFFECTIVE DATE: June 29, 2017

ACTION BY GOVERNOR: Signed April 10, 2017

House Bill 2509

Relating to the practice of telemedicine

This bill provides an exception to the prohibition for prescribing Schedule II drugs via telemedicine when a physician is providing treatment to patients who are minors, or if eighteen years of age or older, who are enrolled in a primary or secondary education program who are diagnosed with intellectual or developmental disabilities, neurological disease, Attention Deficit Disorder, Autism, or a traumatic brain injury in accordance with guidelines as set forth by organizations such as the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry or the American Academy of Pediatrics. The physician must maintain records supporting the diagnosis and the continued need of treatment.

CODE REFERENCE: West Virginia Code §30-3-13a and §30-14-12d – amended

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: April 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2518

Creating a legislative rule to permit a pharmacist or pharmacy intern to administer certain immunizations

The purpose of this bill is to give the Board of Pharmacy rule-making authority to permit a pharmacist or pharmacy intern to administer HPV vaccines and for a pharmacist or pharmacy intern to administer the flu vaccine or HPV vaccine to a person age 11-18 with a prescription and written parental consent.

CODE REFERENCE: West Virginia Code §30-5-7 – amended

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: July 3, 2017

ACTION BY GOVERNOR: Signed April 11, 2017

House Bill 2519

Medicaid program compact

This bill would require the Secretary of the Department of Health and Human Resources to contact our surrounding states to establish a compact to allow health care providers to be paid for services in other states that are provided to other states' Medicaid participants. There is also a required report to the Legislative Oversight Commission on Health and Human Resources Accountability before October 31, 2017.

CODE REFERENCE: West Virginia Code §9-5-25 – new

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: July 3, 2017

ACTION BY GOVERNOR: Signed April 11, 2017

House Bill 2522

Nurse licensure compact

The bill permits the WV Board of Nursing to enter into a licensure compact which would enable a participating practical nurse or registered nurse to be licensed in 25 other states when WV adopts the compact.

CODE REFERENCE: §30-7F-1 through §30-7F-11 – new

DATE OF PASSAGE: April 4, 2017

EFFECTIVE DATE: July 3, 2017

ACTION BY GOVERNOR: Approved - April 25, 2017

House Bill 2526

Classifying additional drugs to Schedules I, II, IV and V of controlled substances.

Under W.Va. Code §60A-2-201, the Board of Pharmacy is responsible for maintaining the list of controlled substances in the schedules in §60A-2 -1 et seq. The Board is required to present the proposed changes to the schedule on the first day of the next Regular Session of the Legislature. The bill contains those proposed changes.

CODE REFERENCE: West Virginia Code §60A-2-201, §60A-2-204, §60A-2-206, §60A-2-210, and §60A-2-212 – amended

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2620

West Virginia Drug Overdose Monitoring Act

This bill creates the Office of Drug Control Policy within the Department of Health and Human Resources. The bill requires the Office to create a state drug control policy in coordination with the Bureaus of the Department and other state agencies. The bill sets forth the duties of the Office, including developing a strategic plan to reduce the prevalence of drug and alcohol abuse and smoking by at least 10% by July 1, 2018, applying for grants and filing semi-annual reports with the Joint Committee on Health. It allows the exchange of information between various agencies. The bill also requires the Office to develop a plan, prior to July 1, 2018, to expand the number of treatment beds in locations throughout the states. This bill requires the Office to establish a central repository to store information required by the Act. The bill sets forth the information required to be reported and specifies those entities that are required to report. Finally, this bill authorizes the Office to propose rules for promulgation and authorizes emergency rules.

CODE REFERENCE: §16-5T-1 through §16-5T-5 – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2628

Relating generally to the powers and duties of the Board of Medicine and the Board of Osteopathic Medicine

This bill clarifies and strengthens the duties and disciplinary authority of the Board of Medicine and the Board of Osteopathic Medicine regarding criminal convictions and evidence of serious misconduct by licensees and applicants for licensure.

CODE REFERENCE: West Virginia Code §30-3-12, §30-3-14, §30-14-11 and §30-14-12a – amended

DATE OF PASSAGE: April 7, 2017

EFFECTIVE DATE: July 6, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2653

Extending the Multi State Real-Time Tracking System

This bill extends the expiration date of the Multi-State Real-Time Tracking System of pseudoephedrine from June 30, 2017 to June 30, 2023. The NPLEX pseudoephedrine sales tracking database is a nationwide database that is provided for free to the states through funding by the pseudoephedrine manufacturers funneled through the National Association of Drug Diversion Investigators. There is no cost to West Virginia government for this database or access to it. The NPLEX database is incorporated into law in West Virginia Code Chapter 60A, Article 10, with requirements on pharmacies as sellers of pseudoephedrine to use it and report into it. There is no revenue generated by the State from this database.

CODE REFERENCE: West Virginia Code §60A-10-16 – amended

DATE OF PASSAGE: April 6, 2017

EFFECTIVE DATE: July 5, 2017

ACTION BY GOVERNOR: Signed April 11, 2017

House Bill 2739

Relating to supplemental Medicaid provider reimbursement

The bill would authorize a “ground emergency medical transportation,” owned or operated by the state, or a city, county, or city and county, that provides ground emergency medical transportation services to Medicaid beneficiaries, receive a “supplemental Medicaid reimbursement” on a per-transport basis or other federally permissible basis if approved by the Centers for Medicare and Medicaid Services.

CODE REFERENCE: West Virginia Code §9-5-25 – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION OF GOVERNOR: Signed April 26, 2017

House Bill 2804

Removing chiropractors from the list of medical professions required to obtain continuing education on mental health conditions common to veterans and family members

This bill removes chiropractic physicians from the list of medical professionals who are required to complete two hours of continuing education for each reporting period in the area of mental health conditions common to veterans and family members of veterans.

CODE REFERENCE: West Virginia Code §30-1-7a – amended

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

House Bill 2846

Including high school students participating in a competency based pharmacy technician education and training program as persons qualifying to be a pharmacy technician trainee

This bill creates the position of pharmacy technician trainee. This position would be regulated by the Board of Pharmacy. To be eligible an applicant should file an application; pay an application fee and have graduated from a high school, obtained a GED, be enrolled in a high school or a board-certified learning institution or training center competency based pharmacy technician education and training program, or be employed in a pharmacy with on the job training.

CODE REFERENCE: West Virginia Code §30-5-11a – new

DATE OF PASSAGE: April 8, 2017

EFFECTIVE DATE: July 7, 2017

ACTION BY GOVERNOR: Signed April 26, 2017

2017 First Extraordinary Session

House Bill 113

Selling of state-owned health care facilities

This bill would allow the Secretary of the Department of Health and Human Resources to sell Jackie Withrow Hospital.

It requires that all patients be appropriately transferred. It also exempts the sale from state purchasing, certificate of need requirements and Medicaid rules and policies. When the Secretary of the Department determines a new facility, it must have at least 90 beds and be built within a 5-mile radius of the current facility, with preference given to company which wants to locate on the same property. The facility shall be a new specialized long-term care facility.

The bill also provides some protections for the employees. In that regard, a benefit plan is to be developed in conjunction with the Division of Personnel. This plan would allow investment in retraining, allow displaced employees to be placed on a preference list for state hiring and allow the purchase of years of service if actuarially sound. There is also a special revenue account which contain the funds for financing the benefit package. There is also a required Memorandum of Understanding with the Division of Personnel, the Consolidated Retirement Board and PEIA to grant the benefits package.

The Secretary is required to provide accounting to the Joint Committee on Government and Finance.

CODE REFERENCE: West Virginia Code §9-5-25 – new

DATE OF PASSAGE: June 16, 2017

EFFECTIVE DATE: September 15, 2017

ACTION OF GOVERNOR: Vetoed June 23, 2017

House Bill 117

Relating to West Virginia Health Care Authority

This bill makes three significant changes to the powers and duties of the Secretary of the Department of Health and Human Resources relative to the move of the Health Care Authority under the purview of the Secretary.

The first change is to the exemptions from certificate of need. Current law allowed for the sale or transfer of skilled nursing beds (nursing home beds) that are currently licensed from one facility within the state to another facility within the state. That provision within our law provides that a state agency may not deny payment for beds which are sold or transferred. This preclusion requires that the beds remain certified in the identical manner as they existed prior to the sale or transfer, thereby making them eligible to be paid for with Medicaid funds. This bill would remove the language which precludes a state agency from denying payment for beds which are sold or transferred. In its place, it would add language that precludes the Department of Health and Human Resources from creating a policy that precludes or limits the transfer of beds. This is a clarification, requested by DHHR, ensures OFLAC may reduce payment if it finds a skilled nursing facility is not in compliance with its regulations. It also removes the exemption permitting a hospital to build an ambulatory health care facility in the county in which the hospital is located.

The second change reinserts language that was eliminated last session with the passage of House Bill 2459. The change would return portions of the financial disclosure language to our code. This would require “covered facilities” to submit reports regarding financial data which is used primarily in certificate of need determinations. The term “covered facilities” is defined to include:

- A Hospital;
- A Behavioral health facility;
- A kidney disease treatment center;
- An intermediate care facility;
- An ambulatory health care facility;
- An ambulatory surgical facility;
- A home health agency;
- A rehabilitation facility; or
- A community mental health or intellectual disability facility.

The bill sets out what data a covered facility or, if requested, a related organization is required to report. These reports shall contain the annual financial report; prepared by an accountant or auditor; reports of services rendered; the Health Care Authority Financial Report through the Uniform Reporting System; and a current Uniform Bill form for each inpatient. This is data that has been reported in the past.

The required data to be reported still excludes previously collected data such as: a statement of ownership of persons owning more than 5% of the capital stock; dividends paid and to whom; a disclosure of ownership by a parent company; a statement of services available; a statement of the total financial needs of the facility; resources available to cover the needs; copies of reports filed with the Federal Health Care Financing Administration; a statement of all charges, fees or salaries for goods or services that exceed \$55,000; a statement of all charges, fees or other sums collected which exceed \$55,000; and tax returns. All of this information was required in the past. There was also a previous requirement to publish all this data through a legal advertisement. That requirement has not been reinstated. As was previously required failure to comply with the required reporting requirements would result in a fine of \$1000 per day.

The bill also sets up a data depository to be operated by the Health Care Authority. This allows the health data collected by the Authority to be reported, maintained, coordinated, processed and disseminated. Minimum reporting requirements are to be set by the Health Care Authority along with standardized forms. There is a preclusion against personally identifiable information. These reports are subject to public inspection. There is also a required report to the Legislative Oversight Commission on Health and Human Resources Accountability before July 1, 2018 and annually thereafter. This report is required to include:

- Submitting entities;
- Data collected;
- Analysis of the data collected;
- A means to reduce duplication; and
- Expenses for operation of the database.

The Secretary is granted emergency rulemaking authority to effectuate the provisions of the article.

The third change is the reinstatement the assessment upon hospitals, except for critical access hospitals. The assessment amount is an amount paid by hospitals on a pro rata basis based upon net patient revenue. This obligation was eliminated in House Bill No. 2459. The assessment amount as set forth in this bill must not exceed five one hundreds of one percent of the net patient revenue of the hospital. As it existed prior to the passage of House Bill No. 2459 the assessment was 1/10th of one percent. The new amount is half of the previous assessment.

The assessment would be paid into a special revenue account. The assessment would be paid twice per year. The first payment would be ½ of annual allowable amount and is due on the first of July. The second would be due after the first of January. The second payment amount is limited to the amount determined to be due to operate the health care authority, but may not exceed the limitation of five one hundreds of one percent of the net patient revenue of the hospital. This assessment is set to sunset on July 1, 2020.

CODE REFERENCE: West Virginia Code §16-2D-11, §16-29B-3, and §16-29B-8 – amended; §16-29B-24 and 25 – new

DATE OF PASSAGE: June 13, 2017

EFFECTIVE DATE: June 13, 2017

ACTION OF GOVERNOR: Signed June 19, 2017

Senate Bill 1004

Relating to modernization of Physician Assistant Practice Act

This bill modernizes provisions of the practice act for physician assistants. It adds a second physician assistant to the make-up of the Board of Medicine. The Board of Osteopathic Medicine currently has two members.

There have been changes to the definition section to insert “collaborating” in place of “supervising”. A number of conforming amendments were added throughout the bill to accommodate this change. The powers and duties of the two licensing boards has been modified to provide that a physician assistant in a collaborating arrangement with a physician may prescribe a monthly supply of Schedule III drugs under certain circumstances and with specified restrictions. There is also a provision which allows an annual prescription of any drug which is prescribed for a chronic condition other than chronic pain management. A chronic condition is defined in the bill.

The requirement that a physician assistant continue to be recertified under the National Commission on Certification of Physician Assistants has been modified. The new provisions provide that once a physician assistant becomes board certified they do not have to keep recertifying annually. This is similar to the manner in which physicians become board certified.

A new provision has been added that would affect the manner in which physician assistants are reimbursed. Currently, they only receive up to 80% reimbursement when they see a patient without their collaborating physician in the room. If the collaborating physician is in the room they receive 100% of the allowable reimbursement. New provisions in this bill would allow 100% reimbursement similar to what the current law provides for physicians and advanced practice registered nurses.

The final change would grant them global signatory authority in a manner identical to that which was given to advanced practice registered nurses during the 2016 Regular Session. They can sign death certificates, order for life sustain treatment, orders for scope of treatment and DNR forms. They may also issue handicap hunting certificates and utility company forms requiring maintenance of utilities regardless of ability to pay.

CODE REFERENCE: West Virginia Code §30-3E-8 – repealed; §16-5-9, §30-3-5, §30-3E-1 through §30-3E-4, §30-3E-6 and §30-3E-7, §30-3E-9 through §30-3E-12, §30-3E-15 through §30-3E-17, and §30-15-14 – amended; §30-3E-12a – new

DATE OF PASSAGE: June 9, 2017

EFFECTIVE DATE: September 8, 2017

ACTION OF GOVERNOR: Signed June 19, 2017

2016 Regular Session



Senate Bill 6

Requiring drug screening and testing of applicants for TANF program

Substance abuse issues have long been part of public assistance policy discussions. States have proposed drug testing of applicants and recipients of public welfare benefits since federal welfare reform in 1996. The federal rules permit drug testing as part of the Temporary Assistance for Needy Families block grant. In recent years, nearly all states have proposed some form of drug testing or screening for applicants. In 2009, over 20 states proposed legislation that would require drug testing as a condition of eligibility for public assistance programs. In 2010 at least 12 states had similar proposals. None of these proposals became law because most of the legislation was focused on “suspicionless” or “random” drug testing, which is at odds with a 2003 Michigan Court of Appeals case. *Marchwinski v. Howard* ruled that subjecting every welfare applicant in Michigan to a drug test without reason to believe that drugs were being used, was unconstitutional.

The proposals gained momentum beginning in the 2011 session. Three states passed legislation in 2011, four states enacted laws in 2012, two states passed legislation in 2013, and three states passed legislation in 2014, bringing the total number of states to twelve. In 2013, Kansas enacted legislation to require drug testing for applicants and recipients suspected of using controlled substances. In 2012, Utah passed legislation requiring applicants to complete a written questionnaire screening for drug use and Georgia passed legislation requiring drug tests for all applicants for Temporary Assistance for Needy Families. Tennessee approved a bill to require the department to develop a plan for substance abuse testing for all applicants and Oklahoma passed a measure requiring all applicants for TANF to be screened for illegal drug use.

As of today, at least thirteen states have passed legislation regarding drug testing or screening for public assistance applicants or recipients (Alabama, Arkansas, Arizona, Florida, Georgia, Kansas, Michigan, Mississippi, Missouri, North Carolina, Oklahoma, Tennessee and Utah.) Some apply to all applicants; others include specific language that there is a reason to believe the person is engaging in illegal drug activity or has a substance use disorder; others require a specific screening process.

Florida's law was halted by a district judge. The District Court issued a final judgment in December 2013 that permanently stopped enforcement of the law saying it violated constitutional protections against unreasonable searches. On December 2, 2014, the 11th U.S. Circuit Court of Appeals upheld the ruling. Tennessee's bill required the department to develop a plan of suspicion-based testing and report its recommendations to the legislature by January 2014. The state began a testing program in July 2014

The bill before this Committee requires the secretary of DHHR to create a three-year pilot program to drug test certain persons applying for benefits from the Temporary Assistance to Needy Families (TANF) Program. The bill requires the secretary to seek the necessary federal approval immediately following enactment of this section and begin the program within 60 days of receiving approval. If federal approval is not granted for any portion of the program, the secretary shall implement the program to meet the federal objections while still operating the program consistent with the purposes of the bill.

Under the pilot program an applicant for whom there exists a reasonable suspicion of substance abuse, as defined in the bill, shall be required to complete a drug test. The cost of the test is paid by DHHR. If the test is positive, the applicant may request further testing at his or her own expense.

A first positive test requires completion of a substance abuse treatment and counseling program and a job skills program approved by DHHR; program participants continue to receive benefits while

participating and are subject to periodic drug screening. Upon a second positive test, the applicant is ordered to a second substance abuse treatment and counseling program and a job skills program but is suspended from receiving benefits for a 12 month period or until completion of the second program. Upon a third positive test, the applicant is permanently terminated from the TANF Program. Refusal to participate or failure to complete a substance abuse treatment and counseling program and a job skills program renders an applicant ineligible. Refusal to take a drug test renders an applicant ineligible.

Any applicant found ineligible to receive TANF as a result of a positive test or a refusal to take a test is subject to an immediate investigation from Child Protective Services. The bill provides that no dependent child's eligibility for benefits may be affected by a parent's failure to pass a drug test or complete a treatment program so designation of a protective payee is authorized when a parent is ineligible.

The bill permits persons who are currently not eligible for benefits under current law because of a prior conviction of a felony drug offense to participate in this pilot program, subject to federal approval.

The bill contains provisions for a due process review of a denial and a one-time reapplication. The bill contains confidentiality provisions, grants emergency rulemaking authority to the secretary, and establishes a misdemeanor offense of intentionally misrepresenting a material fact in an application for benefits. Finally, the bill requires the secretary report to the Joint Committee on Government and Finance by December 31, 2016, and annually thereafter until the conclusion of the pilot program.

CODE REFERENCE: West Virginia Code §9-3-6 – new

DATE OF PASSAGE: March 10, 2016

EFFECTIVE DATE: June 8, 2016

ACTION BY GOVERNOR: Signed March 23, 2016

Senate Bill 10

Creating Unborn Child Protection from Dismemberment Abortion Act

This bill prohibits the practice of a “dismemberment abortion”. The term “dismemberment abortion” is means, with the purpose of causing the death of an unborn child, purposely to dismember a living unborn child and extract him or her one piece at a time from the uterus through use of clamps, grasping forceps, tongs, scissors or similar instruments that, through the convergence of two rigid levers, slice, crush or grasp a portion of the unborn child’s body to cut or rip it off.

A physician or other licensed medical practitioner may perform this type of abortion if he or she determines, based upon his or her reasonable medical judgement, it is necessary to avert death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.

A physician or other licensed medical practitioner who perform a dismemberment abortion is subject to a disciplinary action by their respective boards.

A person who performs a dismemberment abortion is subject to a penalty for the unlawful practice of medicine which is a felony and, upon conviction thereof, shall be fined not more than \$10,000 or imprisoned in a state correctional facility for not less than one year nor more than five years, or both.

CODE REFERENCE: West Virginia Code §16-20-1 – new

DATE OF PASSAGE: February 29, 2016

EFFECTIVE DATE: May 29, 2016

ACTION OF GOVERNOR: Veto March 9, 2016 – Override March 10, 2016

Senate Bill 47

Rewriting licensing requirements for practice of medicine and surgery and podiatry

This bill is to rewrite the licensing exemptions to practice medicine. Most of the changes just update the section for readability and organization. The bill adds several new exemptions to medical licensure including: a member of an air ambulance treatment team or organ harvesting team; a physician serving as volunteer for a charitable function; and a physician treating a visiting sports team.

CODE REFERENCE: West Virginia Code §30-3-13 – amended

DATE OF PASSAGE: March 10, 2016

EFFECTIVE DATE: June 8, 2016

ACTION OF GOVERNOR: Signed March 23, 2016

Senate Bill 68

Disallowing Health Care Authority to conduct rate review and set rates for hospitals

This bill repeals the rate review process. The Health Care Authority established revenue limits for a group of payors termed "nongovernmental payors". This group includes public and private insurers, persons who pay for their own hospital services, and all other third-party payors. The Health Care Authority cannot establish payment rates for the hospital's Medicare, Medicaid or the Public Employees Insurance Agency patients. These programs are strictly controlled by the federal government and state government and were beyond state regulatory powers for rate review purposes.

CODE REFERENCE: West Virginia Code §16-29B-19, §16-29B-19a, §16-29B-20, §16-29B-20a, §16-29B-21 and §16-29B-21a – repealed; §16-29B-1, §16-29B-10 and §16-29B-27 – amended

DATE OF PASSAGE: March 7, 2016

EFFECTIVE DATE: June 5, 2016

ACTION OF GOVERNOR: Signed April 1, 2016

Senate Bill 123

Treatment for sexually transmitted diseases

This bill permits a physician to prescribe antibiotic drugs to the sexual partner of a person clinically diagnosed with a sexually transmitted disease without the physical examination of the partner or partners. The Department will determine what STDs may be treated using the practice by legislative rule.

The treatment is limited to those partners encounter within a 60-day period. The prescriber is required to provide the patient with counseling. This bill provides that a MD, DO, PA, APRN or pharmacist may not be disciplined by their respective boards for performing this practice.

CODE REFERENCE: West Virginia Code §30-3-14, §30-3E-17, §30-5-14, §30-7-11 and §30-14-11 – amended; §16-4F-1, §16-4F-2, §16-4F-3, §16-4F-4 and §16-4F-5 – new

DATE OF PASSAGE: February 16, 2016

EFFECTIVE DATE: May 16, 2016

ACTION OF GOVERNOR: Signed February 26, 2016

Senate Bill 159

Authorizing promulgation of legislative rules by miscellaneous boards and commissions

This bill authorizes miscellaneous agencies and boards to promulgate the following legislative rules. Only the legislative rules directly relating to the health care industry are included in this summary.

West Virginia Board of Examiners in Counseling, Licensing, 27 CSR 1

This rule makes numerous changes to the current legislative rule relating to applications, supervision of applicants, reciprocity, degree accreditation, provisional licenses, areas of competence, retirement status and contact hours in counselor related ethics and mental health conditions specific to veterans and their families.

West Virginia Board of Examiners in Counseling, Licensed Professional Counselor License Renewal and Continuing Professional Education Requirements, 27 CSR 3

This rule amends definitions, clarifies renewal requirements and requires contact hours in counselor related ethics and mental health conditions specific to veterans and their families.

West Virginia Board of Examiners in Counseling, Marriage and Family Therapist Licensing, 27 CSR 8

This rule makes numerous changes to the current legislative rule relating to applications, reciprocity, endorsement review, requirements for supervising professionals, provisional licenses and licensee retirement status.

The House of Delegates amended the rule to more accurately conform to current statute.

West Virginia Board of Examiners in Counseling, Marriage and Family License Renewal and Continuing Professional Education Requirements, 27 CSR 10

This rule amends definitions, clarifies renewal requirements and requires contact hours in counselor related ethics and mental health conditions specific to veterans and their families.

Board of Dentistry, Continuing Education Requirements, 5 CSR 11

This rule sets forth the continuing education requirements for the practice of dentistry. The rule is updated to reiterate the statutory requirement that training also occur on prescribing and administering an opioid antagonist. It also adds the WV Dental Assistants' Association as an approved CLE provider.

Board of Dentistry, Expanded Duties of Dental Hygienists and Dental Assistants, 5 CSR 13

This rule sets forth the permitted duties of dental hygienists and dental assistants. The changes clarify the duties by changing the words "clinical examination" to the word "screening".

WV Medical Imaging & Radiation Therapy Technology Board of Examiners, Radiologic Technologists, 18 CSR 1

This bill amends the current rule to conform to the new fees charged by the American Registry of Radiologic Technologists (AART) for "state only" examinations. An applicant's successful passage of an examination allows practice in West Virginia but is not transferable to any other state. The fees for the radiography, nuclear medicine technology, radiation therapy technology, and post primary mammography have increased from \$100.00 to \$140.00, respectively.

The rule series also adds a \$100.00 fee for any examination the Board would administer. Currently, the Board administers one examination for NMT's who wish to perform CT with a PET scan.

Board of Medicine, Establishment and Regulation of Limited License to practice medicine and surgery at certain state veterans nursing home facilities, 11 CSR 11

This rule creates a limited license to practice medicine and surgery at certain state veterans nursing home facilities for certain qualified individuals.

Nursing Home Administrators Licensing Board, Nursing Home Administrators, 21 CSR 1

This rule sets forth the standards to practice nursing home administration. The rule is updated to permit a person to use administrative experience to count toward the hours required for a person to obtain licensure as a nursing home administrator. It defines terms, including personnel management, planning and organizing, and fiscal management. These terms describe actions which will be included in the term “management experience” which the board will include in its experience calculations. The rule sets forth three circumstances where the board will waive the administrator in training requirement:

An applicant for licensure must complete twelve hours in health care management and 1,000 hours of in an inpatient health care facility; possess a baccalaureate degree; have worked in a certain administrative positions within the long term care field for 3 years; possess a baccalaureate degree or higher from a National Association of Long Term Care Administrator’s Board accredited college program; and have completed an internship or a degree in Health Care Administration, Health Services Administration or similar field that requires the completion of an internship. Applicants must submit to a criminal background check.

WV Board of Pharmacy, Licensure and Practice of Pharmacy, 15 CSR 1

This rule amends the Board of Pharmacy’s rule concerning the licensure and practice of pharmacy.

It adds a section which creates a waiver for special handlings of medications and new innovative practices. It clarifies that it is okay for pharmacies to be “registered controlled substances take back sites” in accordance with DEA regulations. It adds a late fee. It adds more required information on a prescription label. Finally, it specifies under what circumstances a licensee may practice telepharmacy.

WV Board of Pharmacy, Uniform Controlled Substance Act., 15 CSR 2

This rule permits pharmacies properly registered with the DEA as an authorized controlled substances take-back site to operate as such.

It adopts the DEA guidance, which sets forth the circumstances in which a pharmacist may make a change to a prescription written for a controlled substance.

WV Board of Pharmacy, Record Keeping Automated Data Processing Systems, 15 CSR 4

This rule sets forth the requirements on the usage of an automated data processing system. The rule removes old and no longer applicable provisions. It sets forth what information a pharmacist is required to obtain when practicing outside of a pharmacy setting.

WV Board of Pharmacy, Licensure of Wholesale Drug Distributors, Third-Party Logistics Providers and Manufacturers, 15 CSR 5

The changes update the regulation concerning manufacturers, wholesale drug distributors and third party logistics providers. The update is required because of the passage of the Drug Quality and Security Act by Congress. The law preempts states from continuing to license third party logistics providers as wholesale distributors. Therefore, this rule creates a new category for third party logistics provider licensure.

It will treat certain drug compounding facilities as manufacturers if they are bulk selling. Currently, this state licenses out of state manufacturers as whole drug distributors, this is no longer permitted under the DQSA. Out-of-state manufacturers will now be licensed as non- resident manufacturers.

Lastly, the rule adds late fees to wholesale distributors and third party logistics providers who renew late.

Board of Social Work, Qualifications for the Profession of Social Work, 25 CSR 1

During its 2015 Regular Session, the Legislature passed Senate Bill 559 which amended West Virginia Code § 30-30-16 regarding provisional licensure to practice as a social worker. The law became effective on June 7, 2015. The Board of Social Work filed emergency rules pursuant to subsection (b) addressing the eligibility and application process for a newly created exception to the twelve credit hour education requirement for a provisional license. Current West Virginia Code § 30-30-16(c)(2) requires that a provisionally licensed social worker must complete twelve credit hours of core social work study within the four-year provisional license period. Senate Bill 559 includes an exception to that education requirement for a provisionally licensed social worker who is employed by WV DHHR. This category of provisional licensees may satisfy the education requirement “upon completion of the social work training program” with WV DHHR. The Secretary of WV DHHR is required to promulgate legislative rules to implement the training program.

WV Board of Examiners for Speech-Language Pathology and Audiology, Licensure of Speech Pathology and Audiology, 29 CSR 10

This rule change creates a new section six, “Additional Requirements for International Applicants – English as a Second Language Applicants.” The section requires all application documents submitted to the Board be in English or sent with a certified translation into the English language. Any transcript from a foreign college or university must be submitted with a transcript evaluation by a credentials evaluation agency approved by the Board.

Section six also provides that an applicant whose primary language is not English, must meet in person with the Board before a license may be issued. The Board, at its discretion, may conditionally issue a license subject to an English remediation plan and/or restrictions on practice.

The rule amends the required clock hours a Speech-Language Pathology applicant must complete. The amount of required clock hours in Audiology is reduced from 30 to 20.

The rule also amends the required clock hours an Audiology applicant must complete under subsection 12.3. The amount of required clock hours in Speech-Language Pathology is reduced from 30 to 20.

WV Board of Examiners for Speech-Language Pathology and Audiology, Speech-Language Pathology and Audiology Assistants, 29 CSR 2

This rule amends the definition of “Credentialing” by providing that credentialing may take different forms, such as recognition, registration or certification. The rule removes “credentialing” as a possible form and inserts “certification”.

The current rule provides the same language for both speech-language pathology and audiology assistants in regards to their responsibilities. The new rule separates the two professions and outlines differing responsibilities into two separate sections. All the current responsibilities and limitations for a speech-language pathology assistant remain the same under section six. The rule creates a new section seven, outlining specific responsibilities and limitations for an audiology assistant.

The Legislative Rule-Making Review Committee recommended the rule be amended to allow a supervisor of speech-language pathology or audiology to supervise no more than three full-time assistants at any one time. The Legislature adopted the amendment and authorized the rule as modified and amended by the Rule-Making Review Committee.

Board of Medicine, Licensing and Disciplinary Procedures; Physicians; Podiatrists, 11 CSR 1A

The House of Delegates added this rule to the Miscellaneous Bundle. The House amended one section of the current active rule related to the causes for denial, suspension, revocation or other limitations on licenses for osteopathic physicians. One basis for such action is the prescription of Schedule II controlled substances except under certain circumstances. The amendment to this rule would permit an osteopathic physician to prescribe a Schedule II controlled substance for the treatment of a person with a binge eating disorder and suffer no adverse consequences on his or her license.

Board of Osteopathic Medicine, Licensing Procedures for Osteopathic Physicians, 24 CSR 1

The House of Delegates added this rule to the Miscellaneous Bundle. The House amended one section of the current active rule related to the causes for denial, suspension, revocation or other limitations on licenses for osteopathic physicians. One basis for such action is the prescription of Schedule II controlled substances except under certain circumstances. The amendment to this rule permits an osteopathic physician to prescribe a Schedule II controlled substance for the treatment of a person with a binge eating disorder and suffer no adverse consequences on his or her license.

CODE REFERENCE: West Virginia Code §64-9-1 et seq. – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: March 12, 2016

ACTION BY GOVERNOR: Vetoed April 1, 2016 (Vetoed for rule relating to Enterprise Resource Board)

Senate Bill 195

Authorizing DHHR to promulgate legislative rules

This committee substitute bundles the following rules. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health and Human Resources, West Virginia Clearance for Access; Registry and Employment Screening, 69 CSR10

This is a new rule from the Office of the Inspector General within the Department of Health and Human Resources. The rule would create the West Virginia Clearance for Access: Registry and Employment Screening, known as WV CARES. This would require prescreening and criminal background checks on applicants for employment with direct patient access in long term care facilities. The rule was made necessary with the passage of S.B. 88 during the 2015 Regular Session of the Legislature.

The rule sets forth the standard scope, authority, dates, application and enforcement sections. It also defines key terms. Many of these terms are lifted from the authorizing statute. There are some additions such as "Conviction" which has been defined in a similar manner as is currently in other legislative rules or the W. V. State Code; "Fitness Determination" which is defined as a finding by the Secretary after review of an applicant's criminal history record information that the applicant is either eligible for employment or not; and "State Board of Review", which is defined as a board within the Department designated by state law through which an applicant may appeal a negative fitness determination. There has also been greater detail provided for the definition of "Disqualifying Offense". The statute states that the Secretary may specify in the rule other crimes that would constitute a "disqualifying offense".

The rule provides for prescreening of applicants by an internet search of registries and licensure databases. A negative finding would preclude employment. There are also provisions for fingerprinting of applicants whose prescreening produced no negative findings. The collection of fingerprints is for a state and federal criminal history record information check. There are also notice requirements regarding retention of the fingerprints.

Following receipt of the results of the criminal background check the Secretary is required by the rule to make a determination as to the fitness of the applicant for hire. The rule provides that the Secretary may grant a variance if mitigating circumstances, as set forth in the rule, are found to exist by the Secretary. Applicants may also be hired on a conditional basis for 60 days pending the results of the criminal background check.

The rule contains a section which sets forth the appeal process for an adverse decision. It also covers the responsibility of covered providers and contractors. These include record retention and preclusions on employment without the proper background check. There is also a section on changes in employment to over covered providers which would not require fingerprinting and background checks.

Department of Health and Human Resources, Emergency Medical Services, 64 CSR 48

This is an amendment to an existing rule. The changes to the rule are a result of the passage of H.B. 4312 during the 2014 Regular Session of the Legislature. Many of the changes are stylistic and non-substantive.

The definition section was reorganized and updated with no substantive changes. In various places in the rule references to EMS were amended to Emergency Medical Services. There were also changes of a non-substantive nature to the portions of the rule regarding criminal background checks that make it more readable and understandable.

Of a substantive nature, the rule proposes to eliminate certification of Advanced Care Technicians. Any reference to this has been eliminated from the rule. The elimination of this classification is to be phased out over the course of the next two years with complete elimination by March 31, 2017. Consistent with the aforementioned bill, the rule also substitutes the term “EMT-Industrial” for “EMT-Miner” and adjusts the necessary training requirements to mirror the changes to the statute.

The rule also provides for the establishment of up to six (6) community paramedicine demonstration projects. This would allow a two (2) year project for an emergency medical service provider in an out of hospital setting to provide episodic patient evaluation, advice and care to prevent and improve medical conditions which may result in emergency medical services. At the conclusion of the two year project, a report is required to be submitted to the Commissioner of the Bureau for Public Health regarding utilization, analysis of community care and coordination improvement, and reduction in health care costs.

Department of Health and Human Resources, Infectious Medical Waste, 64 CSR 56

This is an amendment to an existing rule. The rule pertains to disposal of medical waste and has not been updated since 1999. Advances in technology, federal regulation, state law and practice have led to the need to update the provisions of the rule. A number of stakeholders and stakeholder groups were invited to participate in the drafting of the changes to the rule.

A number of substantive changes were made to the rule. These include definitions for “hazardous waste” and “waste”. These definitions can be found in Section 3 of the rule. The definitions reference the appropriate definitions of these terms in State code and federal regulations. The rule also updates the notice requirements throughout the rule and requires that public notices include an appropriate e-mail address.

The portion of the rule pertaining to waste management plans (Section 5) has been updated to provide for prevention and mitigation procedures for spills. This section also removes the ability for the Secretary of the Department of Health and Human Resources to grant a waiver for one year for U.S. EPA rules relating to medical waste incineration.

A new subsection (subsection 7.3) has been added to the rule pertaining to small quantity generators. This section contains information on location and contents of kits to provide for rapid and efficient cleanup of spills. It is similar to the provisions for large quantity generators that was in the existing rule. There is also a new subsection (subsection 7.4) which pertains to transportation of infectious medical waste. This section sets forth what must be contained in a transport contamination kit.

The sections pertaining to civil and criminal penalties have been updated to reflect and mirror what is provided for in the West Virginia Code at §22-18-16 and §20-5J-9. Finally, the unnecessary severability section (Section 20) was deleted.

The rule has been updated throughout to include references to applicable federal regulations.

Department of Health and Human Resources, AIDS-Related Medical Testing and Confidentiality, 64 CSR 64

This is an amendment to an existing rule. The rule pertains to procedures for AIDS related testing and confidentiality standards. The amendment to the rule is minimal and corrects an error in the section of the rule pertaining to the data that laboratories must report. The change is in Section 13 of the rule and the amendment changes the language in Subdivision 13.1.b to mirror the reporting requirements in Subdivision 13.1.

Department of Health and Human Resources, Tuberculosis Testing, Control, Treatment and Commitment, 64 CSR 76

This is an amendment to an existing rule regarding tuberculosis testing. The changes were made necessary with the passage of H.B. 2669 during the 2015 Regular Session of the Legislature. That bill eliminated the necessity of requiring all students transferring from a school outside of this state, or enrolling for the first time after moving from another state to furnish a certification from a licensed physician that a skin test was performed within the preceding four months.

The newly amended provisions of the rule simply provide that students who are identified or suspected of active tuberculosis are to be removed from school pending a review of their case by their personal physician and the local health officer. They are only permitted to return after a finding is made by their personal physician, the local health officer and the Commissioner of the Bureau for Public Health that it safe and appropriate. A similar provision is also included regarding school personnel.

The rule also contains a number of drafting and stylistic updates.

Department of Health and Human Resources, The Certification of Opioid Overdose Prevention and Treatment Training Programs, 64 CSR 104

This rule was made necessary by the passage of S.B. 335 during the 2015 Regular Session of the Legislature. That bill provided for first responders to carry an opioid antagonist to administer to persons who are experiencing an opioid overdose. The administration of the antagonist would neutralize the effects of the opioid.

This rule would provide the structure for the training that is necessary for the administration of the antagonist. It contains the standard applicability and purpose sections and defines key terms. It sets forth the necessary factors for the training for competence, skill and education of responders. It also sets out the procedure for distribution of training materials, how the training is to be presented, minimum acceptable proficiency and a certificate of completion.

The means for application and approval of training programs is established in the rule. There is an application process – including a timeline. The process also includes what information must be submitted on the application for approval. There are conditions set forth on what constitutes a complete application and a means for correcting deficiencies. There is also a provision on continuing approval that provides for re-approval in specified circumstances and a provision that allows for on-site reviews of training courses.

The final provision in the bill provides for denial, suspension or revocation of approval if the program fails to meet the statutorily required mandates. This section provides for notice provisions and allows for an administrative hearing which will be conducted in accordance with the WV Administrative Procedures Act.

Department of Health and Human Resources, Chronic Pain Management Licensure, 69 CSR 8

This is an amendment to an existing rule. The rule pertains to licensing procedures and requirement for operation of a pain clinic in West Virginia. The Office of Health Facilities Licensure and Certification began the process of reviewing clinics in July of 2014. Since that time they have realized some amendments are necessary to the rule for it to be fully effective.

The rule was made necessary by the passage of S.B. 437 during the 2013 regular session of the Legislature. It establishes the standard for operation of a pain management clinic.

The rule contains standard scope, applicability, purpose and enforcement sections. It also defines key terms. Notable among these are:

- Chronic Pain - which is pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. Chronic pain does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.
- Opioid Drug Product - any finished dosage form that contains as one of its active ingredients a drug substance that has pharmacological properties similar to morphine, including its analgesic action and its addiction-forming or addiction-sustaining liability, or that can be converted by the body into a drug substance having such properties. Opioid drug products include, but are not limited to, those containing morphine, codeine, hydrocodone and oxycodone.

The amendments proposed to the rule contain a new definition for “Designate Physician Owner”. This is an owner who is fully accountable and responsible for operation of the Clinic who must own at least a 25% share of the business. The Department was finding that owners were owning a very small percentage of the business and no physician was involved in the operation of the clinic. This change would require the physician to take an active role.

The rule contains a separate definition section that defines a pain clinic and sets forth exemptions. This is a privately owned clinic facility or office that treats patients for chronic pain and where more than 50% of all patients in one month are prescribed tramadol, carisoprodol, opioid drugs or other Schedule II or III controlled substances. To reach the 50% mark you divide the average monthly total of patients over a 12 month period by the number of unique patient encounters during any one month for a diagnosis of chronic pain and being prescribed the aforementioned drugs. Exemptions from pain clinics include: a facility associated with a medical school, a facility that does not prescribe controlled substances for treatment of chronic pain, a hospital, a physician practice owned by a hospital, hospice programs, nursing homes, ambulatory surgical facilities, facilities conducting clinical research, state owned hospitals and any facility granted an exemption by the Secretary.

There is a section that pertains to general licensing provisions. New to this section with these amendments would be a provision allowing for a one year license if the clinic does not meet all of the provisions of the rule but their non-compliance does not pose a significant health or safety risk. This section has also been amended to make the required timeframes more readable. It also now contains a section regarding reapplication upon an initial denial.

The rule provides of unannounced inspections and sets forth guidelines for conducting these inspections. Deficiencies found during an inspection may result in a plan of correction. Owners, employees, volunteers and associates of the clinic are required to have a criminal background check. Persons with felony convictions may not own, be employed or associate with a pain clinic. There are also restrictions when a DEA number has been revoked, a license to prescribe controlled substances has been denied or when someone entered a guilty plea on a felony drug charge. Amendments made to the rule lay out what information the Department would be reviewing during an inspection. These include:

- Identifiers of persons receiving treatment;
- Patient diagnosis;
- Demographic information;
- Lists of medications administered, including dates; and
- Access to patient records.

Responsibilities and duties of ownership are spelled out in the rule. These include an annual review of clinic operations. There are also specified licensing, training, education and experience requirements for physician owners. There are also requirements for a clinic administrator. These include job responsibilities and duties and education requirements.

The rule sets forth clinic and facility requirements regarding space, maintenance, security and parking. There are also staffing requirements relative to licensing and credentialing, experience, prohibitions set forth in the rule, developing job descriptions and personnel files. An amendment to this section requires policies and procedures regarding confidentiality of all patient records.

The rule spells out patient rights regarding being informed, the right to receive treatment, the right to participation in developing their plan of care, knowledge of the need to access the controlled substance monitoring database, required drug testing, confidentiality, a safe setting and a grievance procedure.

The requirements for coordination of patient care set out an initial assessment and all that is required of that, the need for subsequent assessments, a plan of care and medication security and administration. This section limits dispensing of any controlled substance to a 72 hour supply. It also requires physicians to access the Controlled Substances Monitoring Database at specified times during the course of treatment. There are also storage, handling, documentation and access requirements set forth in the rule. An amendment to this section provides for laboratory tests and toxicology screening at least every 90 days as part of patient assessments.

Record keeping requirements are set forth in the rule. These include both patient and business records. The rule specifies what must be included in patient records. They are required to meet all state and federal laws, most specifically HIPAA. Records are required to be maintained for 5 years post treatment and shall be kept confidential.

There are specified laboratory requirements that state all clinics need to have the capacity to obtain medication blood levels and urine samples. There is also a requirement that the clinics access quality and performance improvements for patient care at least annually. They are also required to have internal policies regarding quality assessment and performance improvement. This information is to be provided upon request to the Secretary.

The rule requires an effective infection control program that meets nationally recognized standards. The clinic is required to designate a persons to oversee this. They are also required to develop policies regarding adverse events. The rule specifies that these include medication errors, patient suicide, patient deaths, harm to other from ingesting a patient's medication, selling drugs on the premises, drug diversion, harassment or patients by staff, threats and intimidation of staff and violence. Adverse events are required to be reviewed quarterly. Deaths are required to be reported to the Secretary within 48 hours.

Any advertisement regarding the pain management clinic is required to contain the name of the physician owner.

The rule states the grounds for revocation or suspension of a license. A suspension may not last longer than 1 year. There are also requirements for a stay to properly refer and place patients, the need to remove identifying signs, disposition of drugs and a preclusion for a new application within 5 years. Following a revocation the Secretary may considered a new application if all deficiencies have been corrected. An amendment to this section provides for what specific information is required to be shared with the Department upon a revocation, suspension or denial of a license. These include copy of closure notices,

copy of patient letters regarding the closure, the number of effected patients and a copy of the legal advertisement placed in the local paper.

There is a section that permits the Secretary to access a civil penalty for operating a pain clinic without the appropriate license. This section also contemplates injunctive relief to be sought by the Secretary. Finally, the rule allows for necessary due process requirements prior to suspension or revocation of a license and allows the owner to appeal a decision of the Secretary to the Circuit Court of Kanawha County or in a county where the petitioner resides or does business.

Department of Health and Human Resources, Neonatal Abstinence Centers, 69 CSR 9

This is a new rule filed by the Department of Health and Human Resources. The rule became necessary with the passage of H.B. 2999 during the 2015 Regular Session of the Legislature. The rule provides for the licensing of Neonatal Abstinence Centers. Currently only one of these centers exist in West Virginia.

The rule contains the standard general provisions regarding Scope, Authority, Filing Date, etc. It also defines terms. Its sets out the requirements of a license including a process, fees and an inspection. It provides for three types of licenses: initial, provisional and complete. It also contains a procedure for denial of a license if the application is incomplete, the center is operating outside state standards, the inspection was not sufficient or there have been misrepresentations in obtaining the license. There is also a section on license renewal.

The powers and duties of the agency are set forth. These include the application process, inspections - including inspection of records, monitoring of center activities, a complaint process, plans of correction, etc. The specifics of all of these duties are included in the rule and are fairly standard for centers of this nature. There is also a section on penalties. This section allows the oversight agency to levy a fine, suspend or revoke a license. A center is permitted to avail itself of an informal dispute resolution which is set forth in the rule upon a finding of any discrepancies.

There is a section detailing the administrative organization of a center. These provide for a governing body, an administrator, an advisory council, and a quality improvement committee. The duties and responsibilities of each are set forth in the rule. This section also provides for contractual relationships with vendors, professionals, contractors and clinical services. This section details required contract terms, specifics about contracting for clinical and professional services, and record keeping requirements.

There is a fairly standard section regarding the physical facility. This provides for construction and renovation standards, security requirements, requirements for the service environment, laundry and linen requirements, housekeeping and maintenance, storage of supplies, site characteristics, infection control, waste disposal, water supply, sewage disposal, and fire safety, disaster and emergency preparedness.

The rights and responsibilities of the patient, his or her parent and/or legal representative are spelled out in the rule. These include required policy and procedures regarding their rights and responsibilities and availability of these. There are civil rights requirements set forth, a section regarding abuse, neglect and misappropriation of property, a section specific to legal representatives, a staff duties section, specifics regarding informed consent, requirements for confidentiality and access of records and information, visitation standards and requirements, a section pertaining to refusal of treatment and experimental research, a complaint and grievance procedure and a final section dealing with parental participation.

The manner in which a center responds, reacts and resolves incidents and indecent reporting is included. This section provides specificity regarding critical incidents which are those with potential for harm or death to a patient. It also sets forth how they are reported and investigated.

There is a section setting forth the required staff of the center. This requires a medical director who is a physician. His or her responsibilities and duties are set forth. There is a required director of nursing and his or her responsibilities and duties are set forth. There is a necessity for the centers to hire registered professional nurses, social workers, personal care assistants and volunteers. The educational and background requirements of all of these staff functions is set forth in the rule. The rule also specifies necessary staffing ratios, staff training and development requirements necessary personnel record keeping requirements and required criminal background checks.

Criteria for admission and discharge of patients are the facility is set out in the rule. This section also deals with transfer of a patient to another facility.

There is a section that pertains to the plan of care. This sets forth necessary examination, testing standards, standing medical orders, comprehensive assessments, medical and physical assessments, a comprehensive summary of findings, and detail on what is required to be included in the plan of care. It also sets forth the means for development of the plan of care, who is included in its development, timelines and necessary reviews of the plan.

The standards for pharmacological interventions are set out in the rule. This section pertains to proper handling of medications– including storage and disposal, dosage, documentation, labeling and notice requirements to use medications in treatment. Staffing responsibilities are set forth and there is a section dealing with medication errors. There are standards for diversion, theft and loss. There are also requirements for administration of narcotic medications.

Similarly there is a section on non-pharmacological interventions. This pertains to low stimulus environment as patients experience withdraw. There is a section on therapeutic handling and requirements for feeding, transportation and physician services. A section that requires parental education and counseling is also included. This sets forth minimum requirements for parental counseling.

A final section that sets forth standards for medical records and retention is set forth. This section contains the necessary elements to include in a medical record. These standards are substantially similar to other medical record requirements in similar rules. The elements that are necessary to be included in a medical record are set out in the rule.

Department of Health and Human Resources, Child Care Licensing Requirements, 78 CSR 1

This is an amendment to an existing rule which sets forth the minimum licensing requirements for operation of child care centers. The amendments delete the statutorily unsupported provision that allowed parents to provide written documentation exempting their children from immunization requirements for religious reasons. This was made necessary by the passage of S.B. 286 which clarified that any state regulated child care center could not allow any such exemption.

The rule also updated statutory references made necessary with the passage of H.B. 2200 which recodified all of the existing child welfare laws.

Department of Health and Human Resources, Family Child Care Facility Licensing Requirements, 78 CSR 18

This is an amendment to an existing rule which sets forth the minimum licensing requirements for operation of a Family Child Care Facility. There were three substantive changes to the rule.

- The amendments would require that any applicant for a license to operate a family child care facility is required to comply with the federal Department of Agricultural Pest Management. This is a provision that is specifically required by West Virginia Code §49-2-121.
- The amendments delete the statutorily unsupported provision that allowed parents to provide written documentation exempting their children from immunization requirements. This was made necessary by the passage of S.B. 286 which clarified that any state regulated child care center could not allow any such exemption.
- The final change would bring the state into compliance with newly enacted federal regulations within the Consumer Product Safety Commission Standards which preclude the use of any pack and play yard manufactured prior to February 19, 2014.

The rule also updated statutory references made necessary with the passage of House Bill 2200 which recodified all of the existing child welfare laws.

Department of Health and Human Resources, Family Childcare Home Registration Requirements, 78 CSR 19

This is an amendment to an existing rule which sets forth the minimum licensing requirements for operation of a family child care facility. There were three substantive changes to the rule.

The amendments would bring the state into compliance with newly enacted federal regulations within the Consumer Product Safety Commission Standards which preclude the use of any pack and play yard manufactured prior to February 19, 2014.

The rule also updated statutory references made necessary with the passage of H.B. 2200 which recodified all of the existing child welfare laws.

Department of Health and Human Resources, Qualifications for a Restricted Provisional License to Practice as a Social Worker within the Department, 78 CSR 24

This is a new rule from the Bureau of Children and Families within the Department of Health and Human Resources. The rule was made necessary with the passage of S.B. 559 during the course of the 2015 Regular Session of the Legislature. The bill sets forth the provisions for granting a provisional license to practice as a social worker within the Department of Health and Human Resources.

The rule contains standard introductory provisions such as scope and purpose. It also defines key terms. Many of the defined terms were structured to conform to Social Work Examiners Rule 25 CSR 1. Other terms were based upon common usage.

The rule sets out hiring of individuals who are eligible for a Restricted Provisional Social Work License and for completing and documenting initial and ongoing training. There is also a section which sets out the requirements for maintaining the license. These include keeping a license current and active.

The final section of the rule pertains to the development of a Comprehensive Training Program. The authorizing statute required the Department of Health and Human Resources to consult with Higher Education Policy Commission and the West Virginia University and Marshall University Schools of Social Work in development of the rule. Section 6.3 of the rule would expand upon this and also require consultation in the development of the Comprehensive Training Program.

The content of the training curriculum will include content similar to that necessary for a regular Social Work Provisional License. It is also required to include basic and advance social work content and specific content related to the position for which an individual is employed.

Department of Health and Human Resources, Goals for Foster Children, 78 CSR 25

This is a new rule which was made necessary with the passage of H.B. 2527 during the course of the 2015 Regular Session of the Legislature. The rule pertains to goals for children who are in the foster care system. The rule contains the standard Scope and Purpose sections and sets out important dates and statutory authority for the rule.

Key terms are defined in the rule. The rule also sets forth goals that should be attained for a child in the foster care system. These include: protection by the family, nurturing by foster parents, a safe foster home, communication with a person assigned responsibility for the case, permission to remain in school and participation in school activities, communication with biological parents, bank and savings accounts, proper identification documents, contact with siblings and meaningful participation in their transition plan.

There is included in the rule a section related to communication between a foster child and his or her case worker to provide an adequate means for the child to be heard. This provides for immediate attention should the foster child need an issue resolved. This section would require notification to the Circuit Court upon resolution of the issue.

The rule concludes with a section on the burden of proof for ensuring that the goals were met.

CODE REFERENCE: West Virginia Code §64-7-1 et seq. – amended

DATE OF PASSAGE: March 10, 2016

EFFECTIVE DATE: March 10, 2016

ACTION BY GOVERNOR: Signed March 30, 2016

Senate Bill 278

Clarifying physicians' mutual insurance company is not state or quasi-state actor

This bill clarifies that the Physicians' Mutual Insurance Company is not a state actor, or a quasi-state actor, or a quasi-public entity for any purpose.

CODE REFERENCE: West Virginia Code §33-20F-2 and §33-20F-4 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

Senate Bill 404

Removing prohibition on billing persons for testing for HIV and sexually transmitted diseases

The bill rewrites current law primarily to fully authorize health care providers, the Bureau of Public Health and local health departments to recover the costs of testing and treatment for the human immunodeficiency virus (HIV) and other sexually transmitted diseases from certain persons or their insurance companies in the various circumstances under which these tests or treatments are provided.

CODE REFERENCE: West Virginia Code §16-3C-2 and §16-4-19 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

Senate Bill 421

Relating to terminating behavioral health severance and business privilege tax

The bill permanently terminates one tax, and temporarily suspends an exemption from another tax. To that end, the bill terminates the privilege tax (sometimes referred to as the “behavioral health severance tax”) on those who are in the business of providing behavioral health services, effective July 1, 2016. The bill also temporarily suspends the exemption from the sales tax that currently applies to most purchases by a healthcare provider of durable medical equipment. This general suspension of the exemption would last 2 years (June 30, 2018). During that time, however, the purchase of durable medical equipment by a provider that will be provided to patients pursuant to a prescription will continue to be exempt.

CODE REFERENCE: West Virginia Code §11-13A-3 and §11-15-9i – amended

DATE OF PASSAGE: March 3, 2016

EFFECTIVE DATE: June 1, 2016

ACTION BY GOVERNOR: Signed March 8, 2016

Senate Bill 431

Authorizing pharmacists and pharmacy interns dispense opioid antagonists

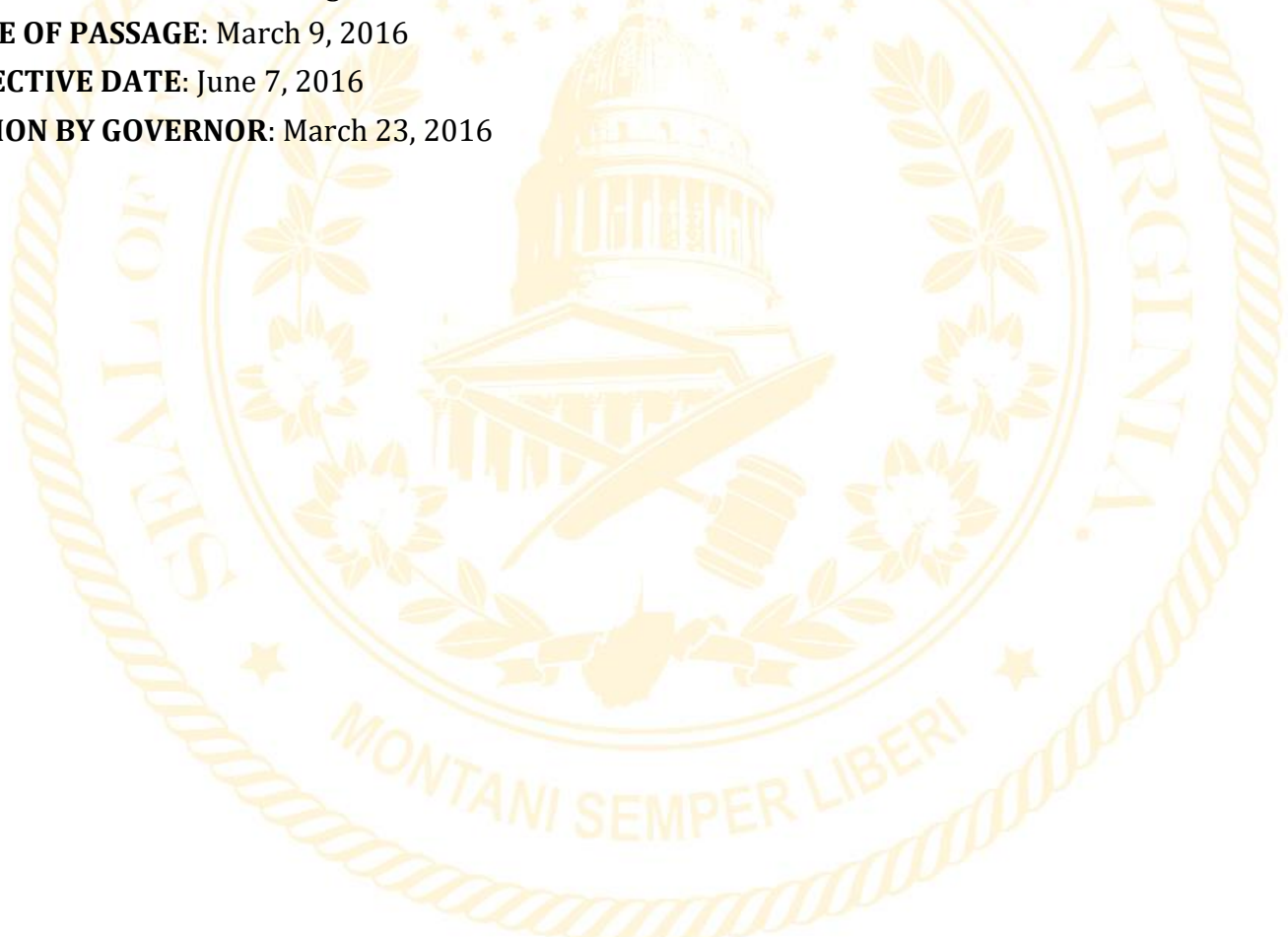
This bill allows for opioid antagonist to be dispensed by a pharmacists or a pharmacy intern without having a prescription. The bill requires patient counseling and documenting of the dispensing. It also provides for informational materials. It also allows for current prescriptions for the antagonist to be refilled. The Board of Pharmacy and the Bureau for Public Health are required to develop protocols, develop the informational/educational materials and develop necessary forms. All of these may be updated periodically. Portions of the bill reorganize existing law for readability. These are the limitations of liability portions of current law. There is also a report that is required to be submitted to the Legislative Oversight Commission on Health and Human Resources. This section has been modified to account for allowing the antagonist to be dispensed without a prescription. A new requirement to this section would require the Board of Pharmacy to query the Controlled Substances Monitoring database for additional data about dispensing of the antagonists and include that in the required report.

CODE REFERENCE: West Virginia Code §16-46-3, §16-46-5, §16-46-6 – amended; §16-46-3a – new

DATE OF PASSAGE: March 9, 2016

EFFECTIVE DATE: June 7, 2016

ACTION BY GOVERNOR: March 23, 2016



Senate Bill 454

Licensing and regulating medication-assisted treatment programs for substance use disorders

This bill regulates medication assisted treatment programs for substance abuse.

The bill creates a new article which sets out licensing requirements. This article defines terms. It requires a license to be issued by the Secretary of the Department of Health and Human Resources and sets out licensing requirements. There are two types of licenses – A registration for office based medication assisted treatment and a license for opioid treatment programs. There are three types of licensing categories – initial, provisional and renewal. There are requirements for applying and renewal licenses including non-transferability of a license and mandated application data.

The bill sets out specific operational requirements.

There is a requirement for patient protocols, treatment plans and profiles and guidelines regarding what is to be included are set forth. There are reporting requirements and a requirements for a physical exam upon initially prescribing a medication assisted treatment as well as a required mental status examination. There is also a preclusion for prescribing and dispensing liquid methadone. Individuals who are permitted to counsel patients include masters level social workers and psychiatrist, psychologist, marriage and family therapist and persons with prescribed bachelor's degrees who are directly supervised by someone with a master's degree.

Restriction on the operation of these facilities is set out in the bill. These include no co- location where patients with chronic pain are being treated – including a pain clinic, a preclusion against recruitment of new patients and a distance requirement of ½ mile in relation to a school. There is also a means to allow the Secretary to grant a variance and a procedure for granting a variance. The bill also provides for annual and unannounced inspections.

The Secretary is given the authority to order a limitation on patients should an inspection reveal inadequate care. Additionally the Secretary may deny, suspend or revoke a license for a violation of the article or any rules adopted under the article. Notice is required in both cases. Any applicant or licensee may request an administrative hearing and if they are unhappy with the results seek redress in the Circuit Court of Kanawha County. A revocation, suspension or denial requires that they clinic cease to operate and an administrative appeal shall not stay the denial, revocation or suspension.

Violation of the newly created article can result in civil penalty levied by the Secretary. Each day of a violation is considered a separate offense. There are penalties for intentional misrepresentation with a civil penalty of \$10,000. There is also a penalty of \$5000 for failure to operate a facility with a valid license and for failure to apply for a new license upon a change of ownership. Unlicensed dispensing of medication assisted treatment can result in a fine of \$20,000. The Secretary is also given authority to file for an injunction. Factors for the Secretary to consider in fixing the amount of the penalty are set out in the bill. Finally, the Secretary may notify the appropriate licensing board if the he or she finds that a physician violated the provisions of the new article.

The moratorium on additional opioid treatment centers remains.

Rulemaking authority is set out in the bill. Mandated rule provisions are set forth with respect to patient care, staff qualifications, the application process, record keeping, procedures for inspection, general operating standards; which drugs may be used, supervision and control of employees, data collection and other standards deemed necessary by the Secretary. The Secretary also is given emergency rulemaking authority.

This bill would add to the list of what must be reported to the Controlled Substance Monitoring Database an opioid antagonist.

The bill would also require all practitioners to register and have online access to the database. Current law only requires that they have online access. Additionally, the bill make licensing of practitioners contingent upon registering with the Controlled Substances Monitoring Program. In addition, it creates a fine to be levied by the appropriate board for failure to register in the amount of \$1,000. There is also a \$500 fine created for failure to properly access the database as required.

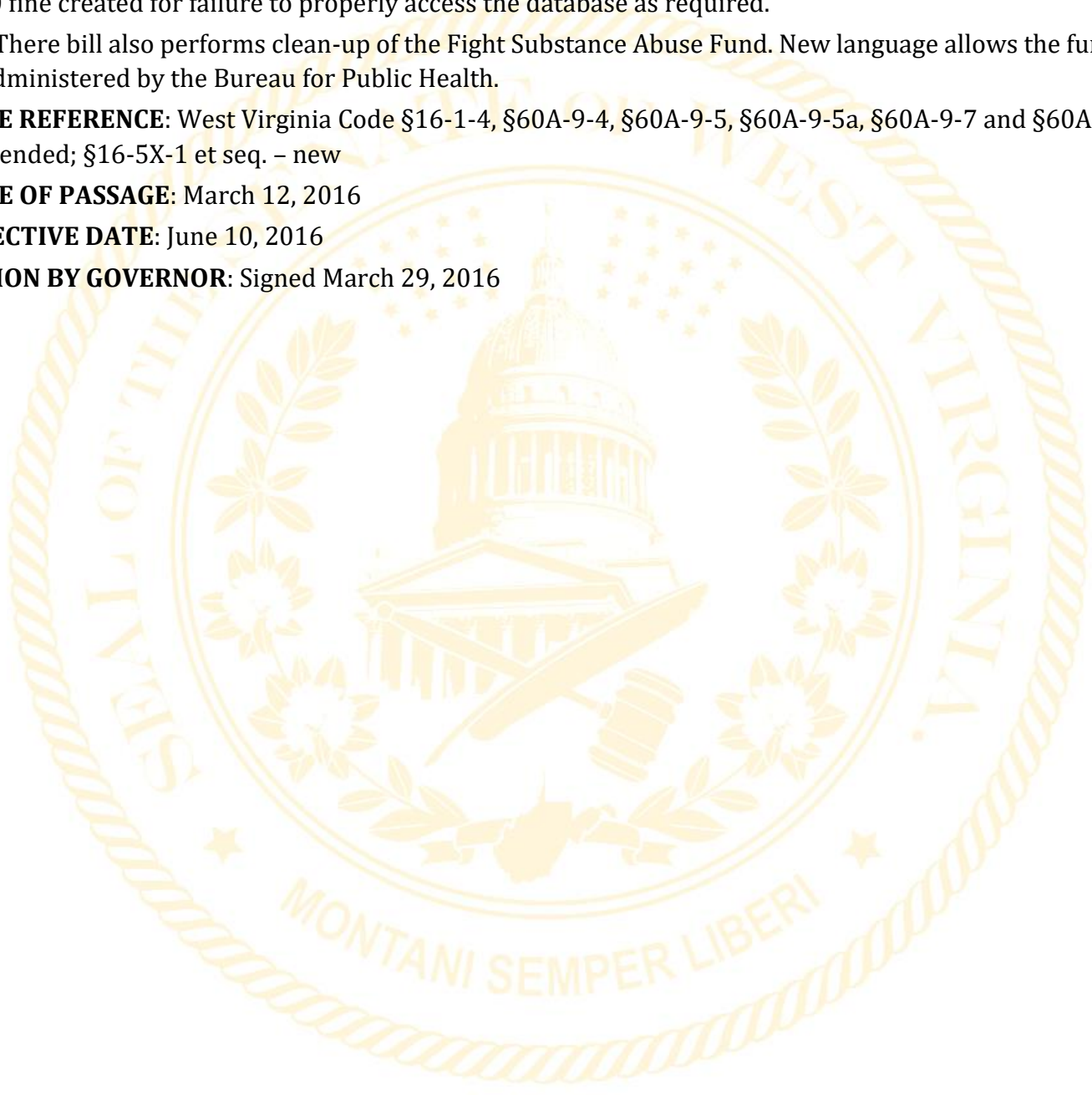
There bill also performs clean-up of the Fight Substance Abuse Fund. New language allows the fund to be administered by the Bureau for Public Health.

CODE REFERENCE: West Virginia Code §16-1-4, §60A-9-4, §60A-9-5, §60A-9-5a, §60A-9-7 and §60A-9-8 – amended; §16-5X-1 et seq. – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 29, 2016



Senate Bill 517

Clarifying PEIA plans that are exempt from regulation by Insurance Commissioner

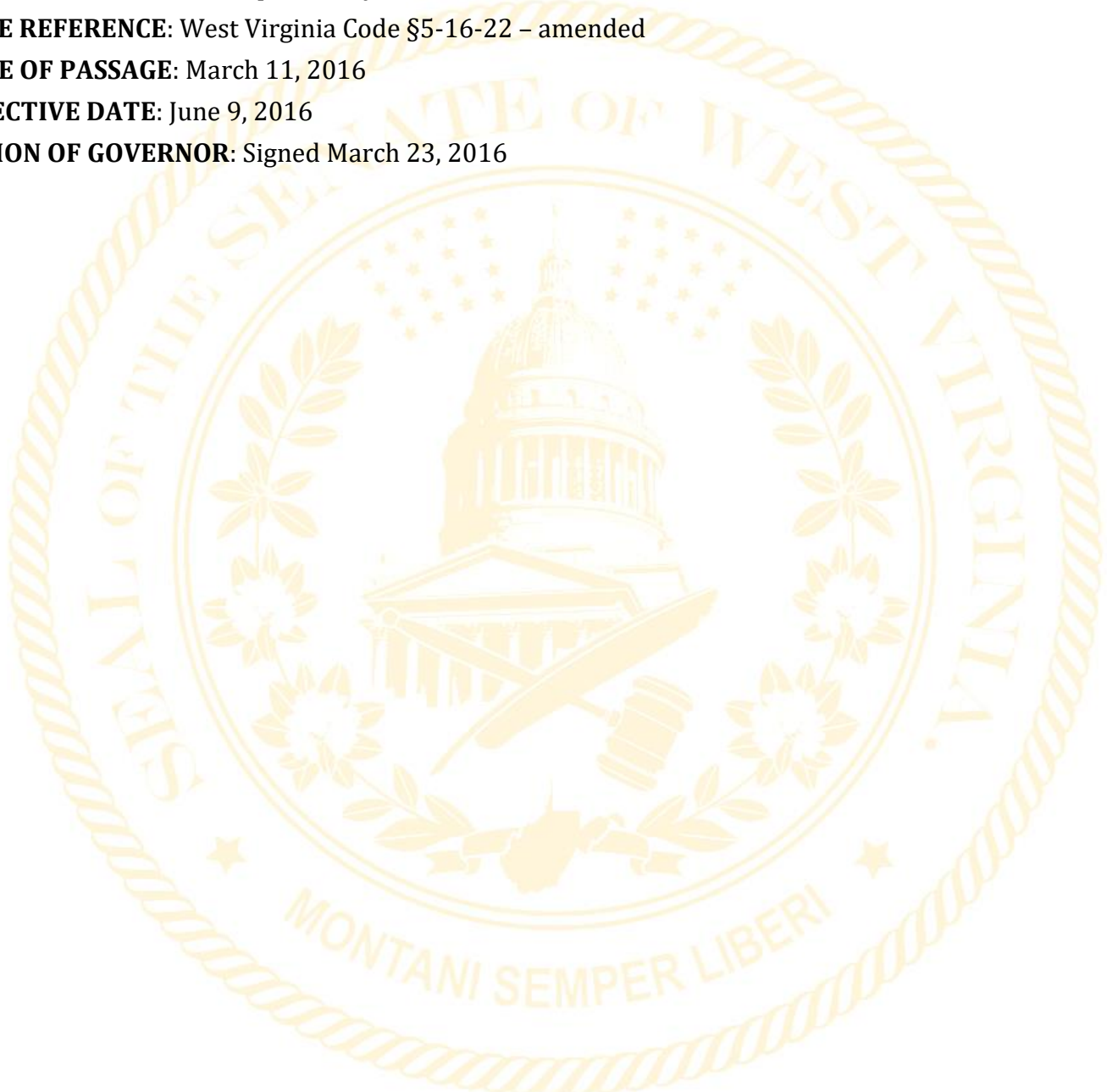
The bill supersedes current statutory to expressly state that all Public Employees Insurance Agency (PEIA) plans are exempt from certain other statutes governing insurance unless explicitly stated. The bill also adds new language expressly stating that PEIA “is not an insurer or engaged in the business of insurance as defined in chapter thirty-three of this code.”

CODE REFERENCE: West Virginia Code §5-16-22 – amended

DATE OF PASSAGE: March 11, 2016

EFFECTIVE DATE: June 9, 2016

ACTION OF GOVERNOR: Signed March 23, 2016



Senate Bill 520

Allowing PEIA ability to recover benefits or claims obtained through fraud

This bill clarifies and enhances the Public Employees Insurance Agency's ability to recover monies paid as a result of fraud. The bill establishes that it shall be a violation of the article for any person to knowingly secure or attempt to secure benefits payable under this article to which they are not entitled; knowingly secure or attempt to secure greater benefits than those to which the person is entitled; willfully misrepresent the presence or extent of benefits to which the person is entitled under a collateral insurance source; willfully misrepresent any material fact relating to any other information requested by the director; willfully overcharge for services provided; or, willfully misrepresent a diagnosis or nature of the service provided.

If it is determined the person has committed any of these violations, after notice and an administrative proceeding, then that person is liable for any overpayment received. The PEIA Director shall withhold and set-off any payment of any benefits or other payment due until the overpayment is recovered. In addition to this civil liability, the bill makes it a felony for any person who knowingly secures or attempts to secure benefits or greater benefits to which the person is entitled under this article by willfully misrepresenting or aiding in the misrepresentation of any material fact related to employment, diagnosis or services. Upon conviction of that felony, the person shall be fined not more than \$1,000, imprisoned for no less than one nor more than five years. The bill makes clear that billing code errors shall not be considered a violation of this felony subsection absent other evidence of willful wrongdoing.

This bill makes it a misdemeanor for any person who violates any provision of this article which results in a loss to or overpayment from the plan or to the State of West Virginia of less than \$1,000 for which no other penalty is provided. Upon conviction, that person is subject to a fine of not less than \$100 but not more than \$500, imprisonment for not less than 24-hours or more than 15 days, or both. This bill makes the same conduct a felony if the loss is greater than \$1,000 to either the plan or the State of West Virginia. The penalties for such a felony would be a fine of not less than \$1,000 or more than \$5,000, imprisonment for a period of not less than one nor more than five years, or both.

The bill also requires employees to provide information to PEIA upon request related to employment or eligibility. The bill also provides certain authority to PEIA to conduct investigations via administrative proceedings and to recover funds due from an employer that knowingly allowed or provided benefits to be paid to an employee or dependents fraudulently. The PEIA Director or designee may administer oaths or affirmations, issue administrative subpoenas, take evidence and require production of documents. The bill also outlines service of such subpoenas including fees to be paid and procedure for failure to comply. The bill provides that only authorized employees or agents may have access to confidential data or systems and applications containing confidential data within PEIA.

CODE REFERENCE: West Virginia Code §5-16-12 and §5-16-12a – amended

DATE OF PASSAGE: March 10, 2016

EFFECTIVE DATE: June 8, 2016

ACTION BY GOVERNOR: Signed March 23, 2016

Senate Bill 602

Relating to Patient Injury Compensation Fund

This bill eliminates the Patient Injury Compensation Fund. The fund was created in 2004 “for the purpose of providing fair and reasonable compensation to claimants in medical malpractice actions for any portion of economic damages awarded that is uncollectible as a result of limitations on economic damage awards for trauma care, or as a result of the operation of the joint and several liability principles and standards set forth in article seven-b, chapter fifty-five of this code.” To effectuate the purpose of eliminating the fund, the bill accomplishes two primary objectives: it provides for the funding of claims that have accrued or will accrue with the Patient Injury Compensation Fund before its closure on July 1, 2016, and it modifies the limitation on liability for treatment of emergency conditions when a patient’s injury arises from treatment at a designated trauma center.

With respect to the limitation of trauma center liability, current law provides that there is an inflation-adjusted cap of \$500,000, inclusive of both economic and non-economic damages. If a patient’s economic damages exceed \$500,000, then the patient may apply to the Patient Injury Compensation Fund to be compensated for economic damages of up to \$1 million. The bill modifies this cap by permitting a patient who would otherwise be eligible for moneys from the Patient Injury Compensation Fund to obtain those moneys from the defendants, but only for economic damages, and only up to an additional \$1 million.

The liability of the Patient Injury Compensation Fund is provided from four primary revenue streams. First, moneys from the Medial Liability Fund are to be transferred to the Patient Injury Compensation Fund. Second, there will be a biennial assessment on physicians (both M.D. and D.O.) in the amount of \$125. Third, there will be an assessment on trauma centers of \$25 for each trauma patient treated. Fourth, there will be a one percent assessment on the gross amount of any settlement or judgment in a claim brought against a trauma center, whether taken to verdict or settled. The assessments run for a period of four years, from July 1, 2016, through July 1, 2020. However, reports are to be submitted by the Board of Risk and Insurance Management to the Joint Committee on Government and Finance beginning January 1, 2018, to update the Legislature on the amount of remaining liability, so that the Legislature can take action, if appropriate, to shorten the length of time the assessments remain in effect.

CODE REFERENCE: West Virginia Code §29-12B-10, §29-12D-1, §29-12D-3, §55-7B-9, §55-7B-9c, §59-1-11, §59-1-28a – amended; §29-12D-1a – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: July 1, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

Senate Bill 627

Permitting physician to decline prescribing controlled substance

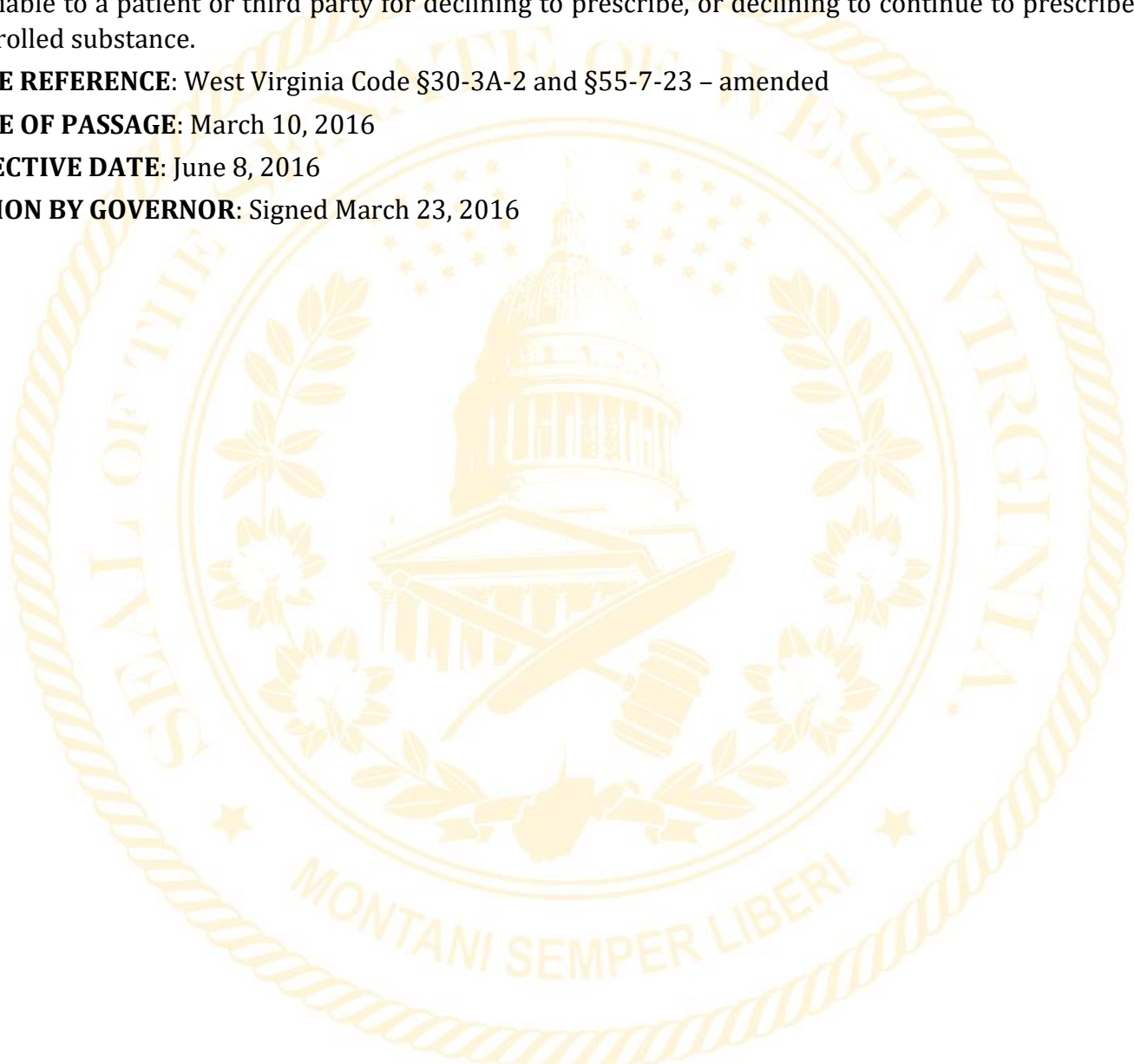
This bill allows a health care provider with prescriptive authority to decline to prescribe any controlled substance to a patient to whom they are providing care, if the health care provider with prescriptive authority, in the exercise of reasonable prudent judgment, believes the patient is misusing the controlled substance in an abusive manner or unlawfully diverting a controlled substance legally prescribed for his or her use without being subject to disciplinary action from his or her licensing board or making him or her liable to a patient or third party for declining to prescribe, or declining to continue to prescribe, any controlled substance.

CODE REFERENCE: West Virginia Code §30-3A-2 and §55-7-23 – amended

DATE OF PASSAGE: March 10, 2016

EFFECTIVE DATE: June 8, 2016

ACTION BY GOVERNOR: Signed March 23, 2016



House Bill 2205

Creating the crime of prohibited sexual contact by a psychotherapist

This bill creates the felony crime of prohibited sexual contact by a psychotherapist by means of therapeutic deception. It provides for elements of the crime, definitions and criminal penalties for the offense of therapeutic deception. Those convicted may be fined not more than \$10,000 or imprisoned in a state correctional facility for not less than one nor more than five years, or both fined and imprisoned.

CODE REFERENCE: West Virginia Code §61-8-30 – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 28, 2016

House Bill 4033

Adding criminal penalties for the unauthorized practice of pharmacists care

This bill clarifies the illegal practice of a pharmacist or a pharmacy technician. This would include practice with an expired, suspended or lapsed license, including licenses impacted by disciplinary action. The illegal practice would carry a fine of \$10,000.

CODE REFERENCE: West Virginia Code §30-5-12b and §30-5-34 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

House Bill 4038

Relating to insurance requirements for the refilling of topical eye medication

This bill sets forth the insurance coverage requirements for the refilling of topical eye medication. This bill permits a person to obtain an early refill of a 30 day prescription for topical eye medication at 21 days. If the person is permitted a refill of the prescription. This change makes insurance requirements consistent with PEIA and CMS standards.

CODE REFERENCE: West Virginia Code §33-15-4M, §33-16-3y, §33-24-7m and §33-25A-8m – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 25, 2016

House Bill 4040

Regulating step therapy protocols in health benefit plans

This bill would require a procedure for exception from a prescription drug step therapy plan. The bill requires the procedure to be easily accessible on a health plans website. There are conditions for granting an exception. These include:

- A required drug is contraindicated;
- The required drug is expected to be ineffective based upon the patient's history;
- Prior use of the drug with no effect;
- The drug is not medically appropriate; and
- The patient is stable on a current prescription.

This section may not prevent a health plan from requiring the use of a generic equivalent or keep a provider from prescribing a drug he or she feels is medically appropriate.

CODE REFERENCE: West Virginia Code §33-15-4m, §33-16-3y, §33-24-7n, §33-25-8k and §33-25A-8m – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

House Bill 4146

Providing insurance cover abuse-deterrent opioid analgesic drugs

The purpose of this bill is to require insurance coverage for at least one abuse-deterrent opioid analgesic drug for each active opioid analgesic ingredient beginning January 1, 2017. The bill would apply to individual and group accident and sickness insurance (Articles 15 and 16); hospital, medical, dental, and health service corporations (Article 24); health care corporations (Article 25); and health maintenance organizations (Article 25A), all in Chapter 33 (Insurance). Cost-sharing, meaning any coverage limit, copayment, coinsurance, deductible or other out of pocket expense requirements, for brand name abuse-deterrent opioid analgesic drug products would not be permitted to exceed the lowest tier for brand name prescription drugs on the entity's formulary for prescription drug coverage. An insured or enrollee would not be required to first use an opioid analgesic drug product without abuse deterrent labeling before being provided coverage for an abuse-deterrent opioid analgesic drug product. Utilization review, including preauthorization, would be permitted if the same utilization review requirements are applied to nonabuse-deterrent opioid analgesic drug products and with the same type of drug release, immediate or extended.

CODE REFERENCE: West Virginia Code §33-15-4m, §33-16-3y, §33-24-7n, §33-25-8k and §33-25A-8m – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION OF GOVERNOR: Signed March 29, 2016

House Bill 4209

Relating generally to health care provider taxes

The bill extends for another year the health care provider tax imposed upon eligible acute care hospitals for the purposes of raising additional revenues to reimburse those hospitals for certain medical services at a higher rate than otherwise authorized by Medicaid, all under the federal matching Upper Payment Limit program. The Legislature has adjusted the rate of this tax annually through its amendment and reenactment of this section of code each year. This year, the rate is changed from .72% of the gross receipts received or receivable by eligible acute care hospitals to .74%.

CODE REFERENCE: West Virginia Code §11-27-38 – amended

DATE OF PASSAGE: March 8, 2016

EFFECTIVE DATE: July 1, 2016

ACTION BY GOVERNOR: Signed March 16, 2016

House Bill 4315

Air-ambulance fees for emergency treatment or air transportation

The bill limits charges that may be imposed by an air-ambulance provider on an employee or dependent of an employee who is covered by a health insurance plan provided by the West Virginia Public Employees Insurance Agency (PEIA) in 2 instances. First, if the air-ambulance provider does not have a contract with the PEIA plan and provides air transportation or related emergency or treatment services to the employee or dependent, then the amount the air-ambulance provider may collect in total from all sources for those services may not exceed “the reimbursement amount then in effect for the federal Medicare program.” Second, if the air-ambulance provider has a “subscription service agreement” for those services with an employee or dependent of an employee covered by the PEIA plan, and the employee or dependent is in good standing with the agreement, then the amount the air-ambulance provider may collect in total from all sources for those services may not exceed “the fee or cost of the subscription service agreement.”

CODE REFERENCE: West Virginia Code §5-16-8a – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 25, 2016

House Bill 4334

Clarifying the requirements for a license to practice as an advanced practice registered nurse and expanding prescriptive authority

This bill was adopted in 2015 and updated the prescriptive practice of an advanced practice registered nurse.

In order to keep this process moving forward, the legislature created this advisory council. The code specifically states what this council shall do. This council is an independent body. The purpose of the Council is to advise the board regarding collaborative agreements and prescriptive authority for advanced practice registered nurses.

But in addition those core functions, the Council may perform the following duties:

- Review and evaluate applications for advanced practice registered nurses to prescribe without a collaborative agreement; - This ultimate decision on an applicant still resides with the board of nursing but you may review and evaluate.
- Assist advanced practice registered nurses with entering into collaborative agreements. Compile a list of willing physicians to assist APRNs in entering a collaborative agreement
- Assist the board in developing and proposing emergency rules;
 - You may assist the board of nursing in developing or proposing emergency rules concerning collaborative agreements and prescriptive authority for advanced practice registered nurses. The ultimate power to submit those rules resides with the board of nursing. This council has no rulemaking authority.
- Review and advise on complaints against advanced practice registered nurses;
- Develop pilot project allowing independent prescribing of controlled substances by APRNs and study results;
- You may create a pilot project allowing independent prescribing of controlled substances by APRNs and study results. This appears to be a broad grant of authority by the legislature to this council providing great latitude to this council on furthering and expanding upon what the legislature has enacted. Study the results and work with the Board of Nursing or the legislature on a full implementation if deemed appropriate.
- Develop other studies and/or pilot projects, including but not limited to:
 - Issues of access, outcomes and cost effectiveness of services;
 - The development of recommendations for reciprocity; and
 - The optimal length of time for transition into independent prescribing;
 - Methods to foster effective interprofessional communication.

CODE REFERENCE: West Virginia Code §30-15-1, §30-15-2, §30-15-3, §30-15-4, §30-15-5, §30-15-6, §30-15-7, §30-15-7a, §30-15-7b, §30-15-7c and §30-15-8 – repealed; §30-7-1, §30-7-2, §30-7-6, §30-7-7, §30-7-15a, §30-7-15b and §30-7-15c – amended; §30-7-15d – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

House Bill 4347

Providing pregnant women priority to substance abuse treatment

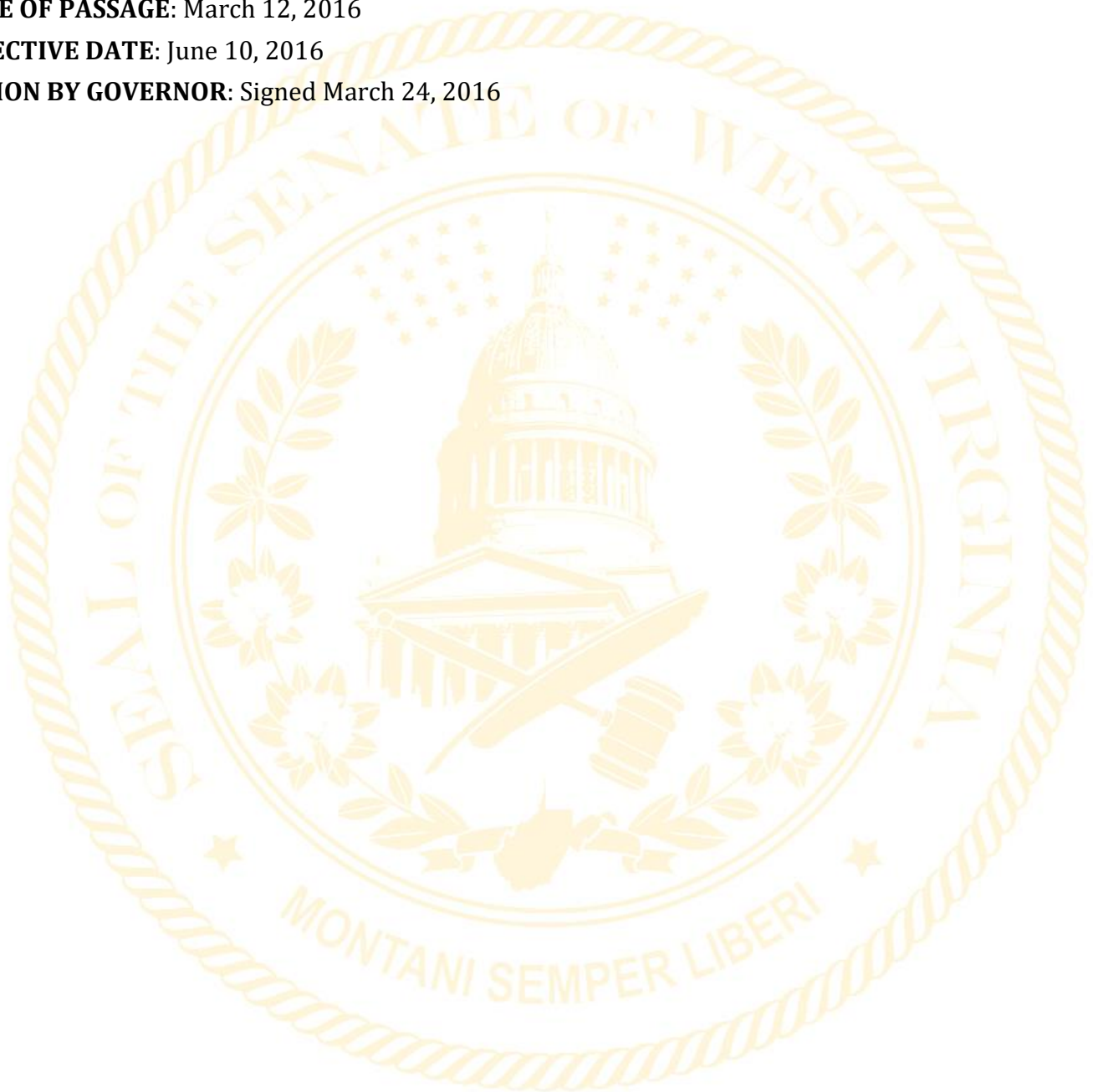
The bill requires substance abuse treatment or recovery service providers that accept Medicaid to give pregnant women priority in accessing services.

CODE REFERENCE: West Virginia Code §9-5-24 – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016



House Bill 4365

Relating to the certificate of need process

The Certificate of Need program was originally enacted in 1977 to comply with a federal mandate to ensure the state continue receiving federal funds for health planning. 35 states have some form of CON. But for PA all of our border states have some type of CON.

Currently, Certificate of need requires health care providers, to obtain a CON before:

- adding or expanding health care services
- exceeding the capital expenditure threshold
- obtaining major medical equipment valued at or more than the capital expenditures threshold
- developing or acquiring new health care facilities.

West Virginia currently requires CON for 26 health services.

The CON review process includes the determination of need, consistency with the State Health Plan, and financial feasibility. Need is determined using CON Standards, which generally include population-based quantifiable need methodologies. Financial feasibility includes the evaluation of the reasonableness of proposed charges to patients and the determination as to whether the expense and revenue projections demonstrate fiscal viability for the proposed project. Other review criteria include quality, accessibility, and continuum of care.

This bill modernizes the Certificate of Need Process.

Specifically, the major change is the establishment of deadlines which will enable to process to proceed to a timely decision. Excluding the number of days an administrative hearing will take the process to obtain a CON from the HCA will conclude in about 205 days. That process is as follows:

- Submit a letter of intent 10 days prior to submitting the certificate of need application.
- The authority shall determine if the submitted application is complete within 10 days of receipt of the application.
- Within 5 days of receipt of a letter of intent, the authority shall provide notification to the public through a newspaper of general circulation in the area where the health service is being proposed and by placing of copy of the letter of intent on its web site.
- The authority may batch completed applications for review on the fifteenth day of the month or the last day of month in which the application is deemed complete.
- When the application is submitted, 10 days after filing the letter of intent, the application shall be placed on the authority's web site.
- An affected party has 30 days starting from the date the application is batched to request the authority hold an administrative hearing.
- A hearing order shall be approved by the authority within 15 days from the last the day an affected person may requests an administrative hearing on a certificate of need application.
- A hearing shall take place no later than 3 months from that date the hearing order was approved by the authority.
- The authority shall render a decision within 45 days of the conclusion of the administrative hearing.
- The hearing shall be held in accordance with the APA.

There is also a new exemption process. The authority has 30 days to review the exemption request. The authority may not hold an administrative hearing to review the application. An affected party may not file an objection to the request for an exemption. The applicant may request or agree with the authority to

a 15 day extension of the timeframe. If the authority does not approve or deny the application within 45 days, then the exemption is immediately approved. If the authority denies the approval of the exemption, the applicant may appeal the authority's decision to the Office of Judges or refile the application with the authority.

A couple of examples of exemptions that are added to the process include:

- A 250K CT scanner;
- Buying or selling skilled nursing facilities;
- Increases the threshold from 3.1M to 5M
- The replacement of major medical equipment with like equipment;
- Renovations within a hospital within its current square footage;
- Renovations to a skilled nursing facility;
- The establishment by a licensed West Virginia hospital of an ambulatory health care facility in the county in which it is located and in a contiguous county within or outside this state;
- The donation of major medical equipment to replace like equipment;
- The Establishment of community mental health and intellectual disability facility;
- Providing behavioral health services;
- The transfer or acquisition of nursing home beds
- Any nonhealth related projects; and
- The establishment of an alcohol or drug treatment facility and drug and alcohol treatment services.

CODE REFERENCE: West Virginia Code §16-2D-4a, §16-2D-4b, §16-2D-5a, §16-2D-5b, §16-2D-5c, §16-2D-5d, §16-2D-5e and §16-2D-7a – repealed; §16-2D-1 through §16-2D-15 – amended; §16-2D-16 through §16-2D-20 – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

House Bill 4388

Relating to stroke centers

This bill permits hospital to apply to the Bureau for Public Health to be designated as a stroke center which will be based upon nationally recognized guidelines. Bureau for Public Health shall send a list of stroke centers to emergency medical service providers. The Bureau for Public Health shall promulgate legislative rules to accomplish the purpose of this section. The office of EMS shall develop protocols to triage and transport stroke patients to the appropriate facility.

CODE REFERENCE: West Virginia Code §16-5b-18 – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

House Bill 4428

Clarifying that optometrists may continue to exercise the same prescriptive authority which they possessed prior to hydrocodone being reclassified

The bill permits an optometrist to prescribe a 72-hour supply of hydrocodone or hydrocodone combination drugs.

CODE REFERENCE: West Virginia Code §30-8-9 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed April 1, 2016

House Bill 4463

Permitting the practice of telemedicine

This bill would authorize the practice of telemedicine. The bill provides that the practice of telemedicine occurs where the patient is located and requires the physicians who practice telemedicine to hold a license issued by the appropriate board. There are also exceptions to the applicability of the section listed in the bill for informal consultation for a second opinion and for medical assistance during an emergency. Preclusions for establishment a physician-patient via telemedicine are also set out.

The manner in which a physician-patient relationship may be established is spelled out in the bill. These include interactive audio and store and forward technology as well as a video link. The bill also sets out the requirements for the practice of telemedicine. These include patient verification, the establishment of a patient relationship, determine the appropriateness of telemedicine for this patient, the use of traditional standards of care and record keeping.

There are standard of care considerations and record keeping requirements. There is also a preclusion against prescribing controlled substances from Schedule I or II of the Controlled Substances Act. The bill would also allow a physician with an established relationship with a patient providing cross coverage for a colleague and in an emergency situation to communicate audio only or text based communications. The bill grants the Board of Medicine and the Board of Osteopathic Medicine rulemaking authority to implement the requirements of the newly created section. Finally, there is a section which indicates that this does not alter the traditional scope of practice of a physician.

CODE REFERENCE: West Virginia Code §30-3-13a and §30-14-12d – amended

DATE OF PASSAGE: March 11, 2016

EFFECTIVE DATE: June 9, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

House Bill 4520

Clarifying that certain hospitals have only one governing body whose meetings shall be open to the public

This bill sets forth what constitutes the governing body of a hospital operated by a nonprofit corporation, a hospital operated by a political subdivision of the State and a hospital operated by a nonprofit association. It specifies that the medical staff of the hospital, its executive committee or a subcommittee of the medical staff is not a governing body.

This bill states that a meeting of any subgroup of the governing body that makes recommendations to the governing body is not a meeting subject to the article which relates to open hospital proceedings, unless the subgroup is vested with and exercises independent decision-making authority at any convening.

Current law prohibits a governing body from taking official action while in executive session. This bill adds several exceptions, such as protecting the confidentiality of protected health information.

Current law also delineates the reasons for which a governing body may go into executive session, including to consider the work product of the hospital's attorney or hospital administration. The bill expands upon this purpose to include conducting privileged attorney client communications and to include materials prepared by an attorney or others in anticipation of litigation, litigation strategies and reports, confidential legal settlements and discussions, negotiations and alternative dispute resolution proceedings conducted in pursuit of a legal settlement.

CODE REFERENCE: West Virginia Code §16-5G-2 and §16-5G-4 – amended

DATE OF PASSAGE: March 8, 2016

EFFECTIVE DATE: June 6, 2016

ACTION BY GOVERNOR: Signed March 23, 2016

House Bill 4537

Relating to the regulation of chronic pain clinics

This bill makes modifications to the Chronic Pain Clinic Licensing Act. These are necessary to close loop holes being used to avoid licensure.

The bill would eliminate an exemption for facilities that are affiliated with medical schools. Apparently some physicians are obtaining letters of affiliation from medical schools when the medical school has no responsibility or oversight with respect to the affiliation.

Finally, the changes would provide clarity of the due process requirements. Current law requires an automatic hearing prior to license suspension. This will place an affirmative duty upon the licensee to request a hearing upon notice of initiation of license suspension proceedings.

CODE REFERENCE: West Virginia Code §16-5H-2, §16-5H-5 and §16-5H-7 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

House Bill 4594

Relating to predoctoral psychology internship qualifications

This bill would alter the requirements of eligibility to practice psychology. Currently, an applicant would be required to have a least one year of experience subsequent to the degree in psychological services.

This bill would change that to a requirement of 1800 hours of a pre-doctoral internship in psychological services.

CODE REFERENCE: West Virginia Code §30-21-7 – amended

DATE OF PASSAGE: March 11, 2016

EFFECTIVE DATE: June 9, 2016

ACTION BY GOVERNOR: March 25, 2016

House Bill 4651

Relating to professional examination requirements for hearing-aid dealers and fitters

This bill modernizes and clarifies the language related to examination requirements for hearing aid dealers and fitters. Applicants for licensure must pass the International Licensing Examination for Hearing Healthcare Professionals, prepared by the International Hearing Society, or an equivalent examination selected by the board. The bill strikes antiquated language related to old tests.

The bill additionally provides emergency rule making authority to modify the legislative rules to update the language to the appropriate test.

CODE REFERENCE: West Virginia Code §30-26-4, §30-26-6 and §30-26-7 – amended

DATE OF PASSAGE: March 9, 2016

EFFECTIVE DATE: March 9, 2016

ACTION BY GOVERNOR: Signed March 25, 2016

House Bill 4654

Relating to the Executive Secretary of the Board of Registered Professional Nurses

This bill removes, the experience requirements for the executive secretary of the Board of Registered Nurses.

CODE REFERENCE: West Virginia Code §30-7-4 – amended

DATE OF PASSAGE: March 7, 2016

EFFECTIVE DATE: March 7, 2016

ACTION BY GOVERNOR: Signed March 10, 2016

House Bill 4655

Prohibiting insurers, vision care plan or vision care discount plans from requiring vision care providers to provide discounts on noncovered services or materials

This bill contains new provisions related to non-covered discounts. It prohibits an insurer from seeking or requiring an eye care provider to provide services or materials at a fee limited or set by the insurer, unless they are reimbursed as covered services or covered materials under the contract. An eye care provider may not charge more for non-covered services or materials than his or her usual and customary rate. Reimbursements paid by the insurer must be reasonable and clearly listed on a fee schedule that is made available before the signing of the contract.

The bill also prohibits insurers from falsely representing benefits to groups, employers or individual enrollees. An agreement may not require an eye care provider to participate with or be credentialed by any specific plan as a condition of participation in the health care network of the insurer. New health benefit plans, vision care plans or vision care discount plans issued or renewed which provides coverage for services rendered by an eye care provider must provide the same reimbursement for services to optometrists as allowed for those services rendered by physicians or osteopaths.

Finally, the bill prohibits an insurer from requiring an optometrist to meet terms and conditions that are not required of a physician or osteopath as a condition of participation in its provider network for the provision of services that are within the scope of practice of an optometrist.

The bill specifies the process for changing or altering an agreement. It allows a person or entity adversely affected by a violation of the law or the Insurance Commissioner to seek an injunction against the insurer and the person or entity may recover monetary damages of no more than \$1,000 for each instance found to be in violation of this section, plus attorney's fees and costs.

CODE REFERENCE: West Virginia Code §33-25E-2 – amended; §33-25E-5 – new

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: July 1, 2016

ACTION BY GOVERNOR: Signed April 1, 2016

House Bill 4659

Authorizing local health departments to bill health insurance plans for services

The bill amends the provisions of the West Virginia Code relating to the powers and duties of local boards of health. The bill authorizes local health departments to bill a payor for medical services provided at the maximum allowable rate and that the fees for medical services are not subject to the approval of the Commissioner of the Bureau for Public Health.

CODE REFERENCE: West Virginia Code §16-2-11 – amended

DATE OF PASSAGE: March 12, 2016

EFFECTIVE DATE: June 10, 2016

ACTION BY GOVERNOR: Signed March 24, 2016

House Bill 4728

Relating to schedule three controlled substances

This bill would add human chorionic gonadotropin to the list of Schedule III drugs. There is an exception of the use of the drug on nonhuman species and when approved by the FDA.

CODE REFERENCE: West Virginia Code §60A-2-208 – amended

DATE OF PASSAGE: March 11, 2016

EFFECTIVE DATE: June 9, 2016

ACTION BY GOVERNOR: Signed March 29, 2016

House Bill 4735

Relating to the definition of health care provider, and clarifying that speech-language pathologists and audiologists are two separate providers

This bill clarifies that speech-language pathologists and audiologists are two separate providers.

CODE REFERENCE: West Virginia Code §55-7B-2 – amended

DATE OF PASSAGE: March 7, 2016

EFFECTIVE DATE: June 5, 2016

ACTION BY GOVERNOR: Signed March 10, 2016

2015 Regular Session



Senate Bill 6

Relating to medical professional liability

This bill amends and updates the Medical Professional Liability Act. A new legislative finding is added in §55-7B-1 to explain the reasons for updating the Act, explaining that the “modernization and structure of the health care delivery system necessitate and update of provisions of this article” in order to allow the Act to continue to fulfill its purposes, which are “to control the increase in the cost of liability insurance and to maintain access to affordable health care service for our citizens.”

The bill also updates and clarifies a number of definitions in §55-7B-2. The definition of “collateral source” is modified to exclude from its reach the amount of any reductions, discounts or write-offs of a medical bill. “Health care” is also amended and expanded to clarify that ordinary activities that occur in the regular course of providing treatment to patients and are related to the provision of health care fall within the definition. The terms “health care facility” and “health care provider” are expanded to bring within the scope of the definition additional types of facilities and providers. “Medical professional liability” is amended to include “other claims that may be contemporaneous to or related to the alleged tort or breach of contract or otherwise provided in the context of rendering health care services.” A new definition is provided for “related entity,” which includes all business entities “under common control or ownership . . . with a health care provider or health care facility,” or any entity that owns a health care provider or health care facility.

Next, the bill addresses testimony of expert witnesses on the standard of care in §55-7B-7, providing that an proposed expert witness may only be found competent to testify if, among other qualifications, his opinion is grounded on a scientifically valid and properly applied methodology.

A new section of code is added, §55-7B-7a, which concerns the admissibility and use of certain information. The bill creates a rebuttable presumption that certain information, including:

- surveys, audits and reviews of a health care provider or facility
- disciplinary actions against a health care provider’s license, registration or certification
- accreditation reports
- civil or criminal penalties, cannot be introduced unless it applies specifically to the injured person or involves substantially similar conduct and occurred within one year of the particular incident in question

An additional rebuttable presumption provides that, if a health care facility meets the minimum staffing ratio established under state law, that evidence of inadequate staffing cannot be admitted.

The bill provides, in §55-7B-8, for modifications to the Act’s liability limitations for noneconomic loss. Specifically, the bill clarifies the level of coverage necessary in order for a defendant to have the benefit of the limitations on noneconomic damages, explicitly stating that the coverage at issue must be at least one million dollars in the aggregate. In §55-7B-9, the bill adds language to clarify that a health care authority may not be held vicariously liable for the acts of a non-employee, unless the non-employee fails to maintain professional liability insurance in the amount of \$1 million for each occurrence.

§55-7B-9c clarifies that the Act applies to emergency medical services (EMS) authorities or EMS personnel. The bill also adds language to ensure that the \$500,000 cap on civil damages recoverable against EMS authorities and personnel is for each occurrence, regardless of the number of plaintiffs, defendants, or distributees. An inflation adjuster is also added at the end of this section, which becomes effective January 1, 2016.

A new section, §55-7B-9d, is added that limits a verdict for past medical expenses to (1) the total amount of medical expenses paid by or on behalf of the plaintiff, and (2) the total amount of medical expenses incurred but not paid for which the plaintiff or another is obligated to pay.

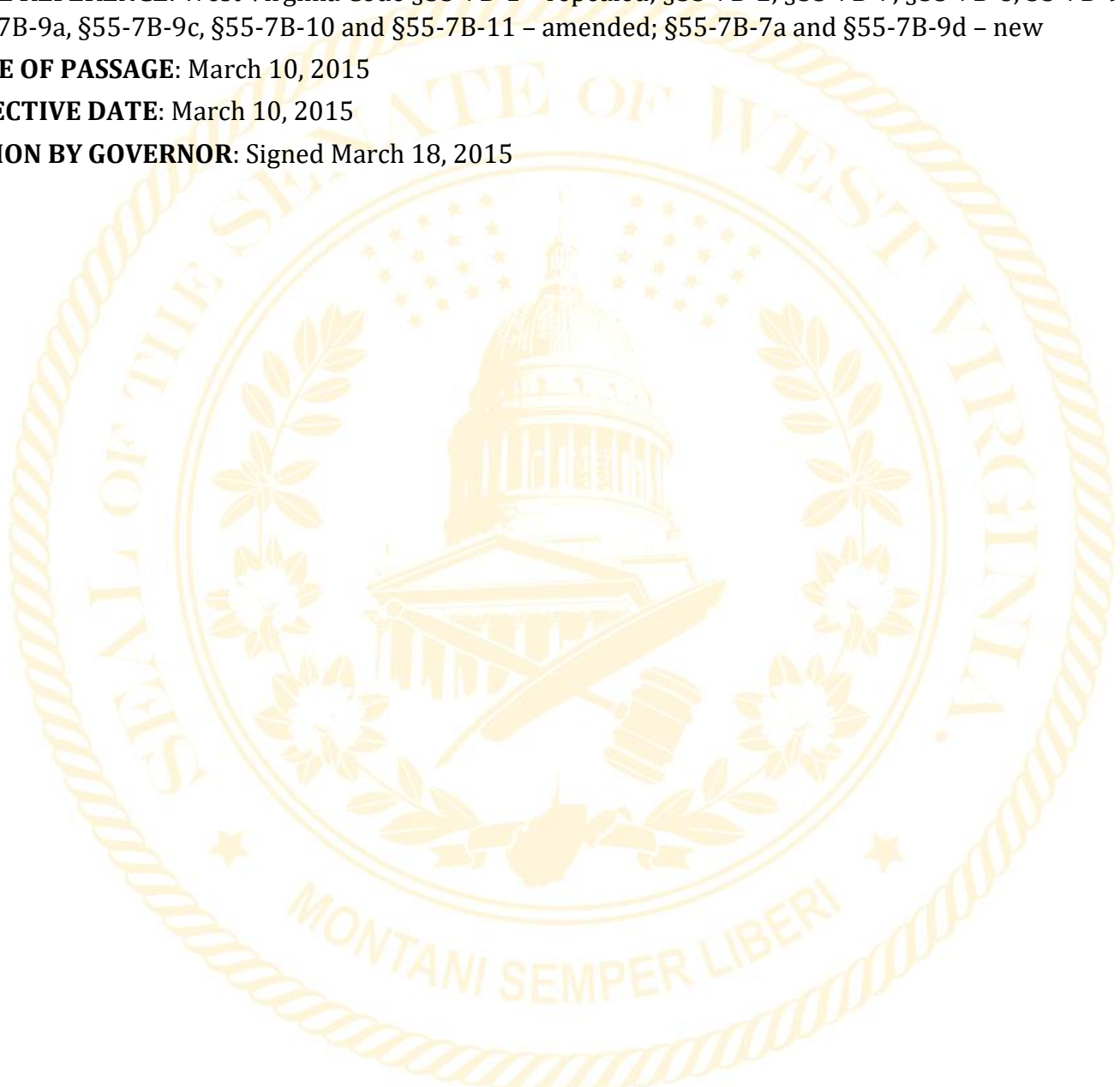
Finally, technical changes are made throughout, including in §55-7B-9a. The bill clarifies in §55-7B-10 that the changes made in this bill apply only to claims filed on or after July 1, 2015, and updates the severability language found in §55-7B-11.

CODE REFERENCE: West Virginia Code §55-7B-1 – repealed; §55-7B-2, §55-7B-7, §55-7B-8, 55-7B-9, §55-7B-9a, §55-7B-9c, §55-7B-10 and §55-7B-11 – amended; §55-7B-7a and §55-7B-9d – new

DATE OF PASSAGE: March 10, 2015

EFFECTIVE DATE: March 10, 2015

ACTION BY GOVERNOR: Signed March 18, 2015



Senate Bill 7

Requiring CPR and care for conscious choking instruction in public schools

This Act modifies requirements for the CPR and first aid instruction required to be taught in any of the grades 6 through 12 in public school health education.

The first aid instruction must now include instruction in the care for conscious choking and the recognition of symptoms of drug or alcohol overdose.

The currently required instruction in cardiopulmonary resuscitation now must consist of a minimum of thirty minutes of instruction and the psychomotor skills necessary to perform it prior to graduation. The CPR instruction must be based on a program established by American Heart Association or The American Red Cross or other recognized guidelines. School districts may exceed the minimum requirements, but instruction that results in a certification being earned requires an authorized CPR/AED instructor.

A licensed teacher is not required to be a certified CPR trainer to facilitate, provide or oversee such instruction. The instruction may be given by community members, such as emergency medical technicians, paramedics, police officers, firefighters, licensed nurses and representatives of the American Heart Association or the American Red Cross. These community members are encouraged to provide necessary training and instructional resources such as CPR kits and other material at no cost to the schools.

The CPR requirements are minimum requirements and school districts may offer the instruction for longer periods of time and may enhance the curriculum and training components, including, but not limited to, incorporating into the instruction the use of an automated external defibrillator (AED)

The Act also strikes a criminal provision that any person violating the section is guilty of a misdemeanor and, if a school employee, must be removed from the position and ineligible for reappointment or a similar position for one year.

CODE REFERENCE: West Virginia Code §18-2-9 – amended

DATE OF PASSAGE: February 12, 2015

EFFECTIVE DATE: July 1, 2015

ACTION BY GOVERNOR: Signed February 24, 2015

Senate Bill 88

Creating WV Clearance for Access: Registry and Employment Screening Act

This bill would create the West Virginia Clearance for Access: Registry and Employment Screening program. The program would provide for background and fingerprint checks on individuals who are applicants to providers who are covered under the program. Providers would be precluded from employing an individual who was not subject to a background check who has direct access to patients. The bill provides for notice to applicants of adverse findings.

There are provisions for a variance and sets forth the reasons that the Secretary may grant a variance. Most notable is that the person does not pose a danger or threat to residents or patients. There is also a procedure for appeal if the applicant feels the information obtained regarding them is incorrect and a provision for a sixty day conditional employment pending the results of the background check.

The bill would grant legislative rulemaking authority to draft rules to effectuate the purpose of the section. There is also a provision that would allow for the imposition of fees on applicants or providers.

CODE REFERENCE: West Virginia Code §16-46-1 through §16-46-9 – new

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION BY GOVERNOR: Signed April 2, 2015

Senate Bill 175

Authorizing DHHR promulgate legislative rules

This is the bundled rules bill for the Department of Health and Human Resources. Only the legislative rules directly relating to the health care industry are included in this summary.

Department of Health and Human Resources, Chronic pain management clinic licensure, 69 CSR 8

This is an amendment to an existing rule of the Office of Facility Licensure and Certification. This rule passed the Legislature in 2013. At that time, the effective date of the rule provided that it would become effective upon funding for implementation being included within a “duly enacted appropriation bill authorizing the expenditure of funds for that purpose”. That funding was in the Fiscal Year 2015 Budget which became effective on July 1, 2014. The only change to the rule was to amend the effective date to make it effective July 1, 2014. All other provisions of the rule remain intact as passed by the Legislature during the 2013 regular session.

Due to the contentious nature of the rule included herein is a description of the provisions for informational purposes to the Committee:

The rule was made necessary by the passage of Senate Bill No. 437 during the 2013 regular session of the Legislature. It establishes the standard for operation of a pain management clinic.

The rule contains standard scope, applicability, purpose and enforcement sections. It also defines key terms. Notable among these are:

- **Chronic Pain** - which is pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause and that has continued, either continuously or episodically, for longer than three continuous months. Chronic Pain does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition.
- **Opioid Drug Product** - any finished dosage form that contains as one of its active ingredients a drug substance that has pharmacological properties similar to morphine, including its analgesic action and its addiction-forming or addiction-sustaining liability, or that can be converted by the body into a drug substance having such properties. Opioid drug products include, but are not limited to, those containing morphine, codeine, hydrocodone and oxycodone.

The rule contains a separate definition section that defines a pain clinic and sets forth exemptions. This is a privately owned clinic facility or office that treats patients for chronic pain and where more than 50% of all patients are prescribed tramadol, carisoprodol, opioid drugs or other Schedule II or III controlled substances. To reach the 50% mark you divide the average monthly total of patients over a 12 month period by the number of unique patient encounters during any one month for a diagnosis of chronic pain and being prescribed the aforementioned drugs. Exemptions from pain clinics include: a facility associated with a medical school, a facility that does not prescribe controlled substances for treatment of chronic pain, a hospital, a physician practice owned by a hospital, hospice programs, nursing homes, ambulatory surgical facilities, facilities conducting clinical research, state owned hospitals and any facility granted an exemption by the Secretary.

There are fairly standard licensing procedures. It specifically provides that a license is non-transferrable. Changes in ownership and management are to be reported. The rule also allows the Secretary to enter any premises to ascertain if it is operating as a pain clinic without a license and requires

such facilities to apply for the appropriate license if it is determined that a pain clinic is being operated. The rule specifies what must be included in an application for a license, provisions for an initial license, a license renewal and a denial of a license. Licenses expire after one year. The rule contains licensing fees based upon capacity. Facilities are also required to cover the cost of a required inspection.

The rule provides of unannounced inspections and sets forth guidelines for conducting these inspections. Deficiencies found during an inspection may result in a plan of correction. Owners, employees, volunteers and associates of the clinic are required to have a criminal background check. Persons with felony convictions may not own, be employed or associate with a pain clinic. There are also restrictions when a DEA number has been revoked, a license to prescribe controlled substances has been denied or when someone entered a guilty plea on a felony drug charge.

Responsibilities and duties of ownership are spelled out in the rule. These include an annual review of clinic operations. There are also specified licensing, training, education and experience requirements for physician owners. There are also requirements for a clinic Administrator. These include job responsibilities and duties and education requirements.

The rule sets forth clinic and facility requirements regarding space, maintenance, security and parking. There are also staffing requirements relative to licensing and credentialing, experience, prohibitions set forth in the rule, developing job descriptions and personnel files.

The rule spells out patient rights regarding being informed, the right to receive treatment, the right to participation in developing their plan of care, knowledge of the need to access the controlled substance monitoring database, required drug testing, confidentiality, a safe setting and a grievance procedure.

The requirements for coordination of patient care set out an initial assessment and all that is required of that, the need for subsequent assessments, a plan of care and medication security and administration. This section limits dispensing of any controlled substance to a 72 hour supply. It also requires physicians to access the Controlled Substances Monitoring Database at specified times during the course of treatment. There are also storage, handling, documentation and access requirements set forth in the rule.

Record keeping requirements are set forth in the rule. These include both patient and business records. The rule specifies what must be included in patient records. They are required to meet all state and federal laws, most specifically HIPAA. Records are required to be maintained for 5 years post treatment and shall be kept confidential.

There are specified laboratory requirements that state all clinics need to have the capacity to obtain medication blood levels and urine samples. There is also a requirement that the clinics access quality and performance improvements for patient care at least annually. They are also required to have internal policies regarding quality assessment and performance improvement. This information is to be provided upon request to the Secretary.

The rule requires an effective infection control program that meets nationally recognized standards. The clinic is required to designate a persons to oversee this. They are also required to develop policies regarding adverse events. The rule specifies that these include medication errors, patient suicide, patient deaths, harm to other from ingesting a patient's medication, selling drugs on the premises, drug diversion, harassment or patients by staff, threats and intimidation of staff and violence. Adverse events are required to be reviewed quarterly. Deaths are required to be reported to the Secretary within 48 hours.

Any advertisement regarding the pain management clinic is required to contain the name of the physician owner.

The rule states the grounds for revocation or suspension of a license. A suspension may not last longer than 1 year. There are also requirements for a stay to properly refer an place patients, the need to remove identifying signs, disposition of drugs and a preclusion for a new application within 5 years. Following a revocation the Secretary may considered a new application if all deficiencies have been corrected.

There is a section that permits the Secretary to access a civil penalty for operating a pain clinic without the appropriate license. This section also contemplates injunctive relief to be sought by the Secretary. Finally, the rule allows for necessary due process requirements prior to suspension or revocation of a license and allows the owner to appeal a decision of the Secretary to the Circuit Court of Kanawha County or in a county where the petitioner resides or does business.

Department of Health and Human Resources, Medication administration and performance of health maintenance tasks by approved medication assistive personnel, 64 CSR 60

This is an amendment to an existing rule. Last session this rule was also amended. Those amendments provided for updates to definitions and to the administration of medication which was altered to account for the performance of health maintenance tasks to specifically limit delegation only to those tasks which, after a registered professional nurse makes the appropriate decision, may be properly delegated.

The current changes add definitions that were included in House Bill 4287. These include definitions of family, immediate family, natural supports, pre-filled insulin or insulin pen and primary health care professional. Most substantive are modifications to the definitions of “health maintenance tasks” which now includes administration of pre-filled insulin pens, performing tracheotomy care and ventilator care. These were all permitted under the 2014 statutory change.

The rule also makes modifications to the instruction and training section. These changes are also consistent with the 2014 statutory changes. These include a reorganization of the competency evaluation section and additional retraining requirements.

Finally, the rule was updated to allow orders by a physician or authorized health care professional. Previously, the rule would only allow orders from a physician. There is also a preclusion from performing tracheotomy and ventilator care in specified facilities not authorized by the statute.

Department of Health and Human Resources, Nurse aid abuse and neglect registry , 69 CSR 6

This is an amendment to an existing rule. The changes being made update the rule to industry best practices to protect the rights of residents in nursing homes and to protect the rights of nurse aides.

The definition section was amended to expand the definition of abuse which now includes a definition of “emotional abuse”. There were also modification made to the definition of sexual abuse to include “sexual exploitation, sexual contact, or graphic images of a resident’s body - including private areas”. The definition of verbal abuse was rewritten for clarification.

A new section was added to the rule providing detail regarding the responsibilities of a nurse aide. These duties will include:

- Safeguarding a resident to provide for a dignified existence;
- Ensuring the resident is free of abuse and neglect;
- Reporting requirements for abuse and neglect;
- Maintaining information with the registry regarding personal data of the nurse aide;
- Maintaining current employment data with the registry by the nurse aide;
- Reporting of changes in criminal history to the registry;
- Maintaining a copy of this rule; and,

- Appearing as a witness to an abuse and neglect hearing pursuant to a valid subpoena.

The reporting requirements section was updated to current practices and to be consistent with other sections throughout the rule. The section regarding determination was added to provide detail on the requirements for disposition of an investigative report. Finally, the section regarding hearings was rewritten to provide that all hearings are now held by the Board of Review. This section also provides specific notice and confidentiality requirements and clarifies the nurse aide's right to appear with counsel. There are also specific requirements for issuing a written decision by the Board of Review.

Department of Health and Human Resources, Nursing home licensure, 64 CSR 13

This is an amendment to an existing rule of the Office of Health Facility Licensure and Certification for licensure procedures for nursing homes. The changes were made necessary by the passage of House Bill No. 3108 during the 2014 Regular Session. That bill required criminal background checks on all applicants prior to permanent employment.

The changes to the rule include updates of definitions. Added are definitions that are relative to criminal background checks such as "conviction", "direct access", "direct access personnel", "disqualifying offense", "fitness determination" and "negative finding". There were also additions or modifications to existing definitions. These include: "abuse", "full time employee", "legal representative", "Office of Health Facility Licensure and Certification", "repeat deficiency", "resident resource amount", "state board of review" and "substantial compliance".

The rule contains a number of updates to make the rule compliance with federal law and recent statutory changes. These include a rewriting of the section regarding Legal Representation. The provisions of that section were not materially changed, just clarified. There were also changes to make it more clear that a resident may choose his or her personal physician and pharmacy. Changes for consistency were also made to the section pertaining to Conveyance Upon Death or Discharge.

Patient rights regarding discharge was made more clear and a section regarding Discharge Against Medical Advice was added. Clarity was also given to the section regarding Visitation to make it clear that 24 hour visitation privileges may be granted to any individual approves by the resident. A nursing home is permitted to impose reasonable restrictions for security purposes.

New language was added regarding paid feeding assistants. This includes duties that are permitted to be performed by a paid feeding assistant. There is also new language regarding posting of nurse staffing information which includes what data must be posted.

There is a new section regarding the requirement for a criminal background check. This section includes pre-screening procedures, fingerprinting - which includes notice requirements, retention and lapses in employment - a determination of the employees fitness for the position, the use of conditional employees pending the background check, variances which may be granted by the Secretary, an appeal process, responsibilities of the nursing home, which include record retention, the need to complete the background check and civil penalties for failure to comply. There is also a provision for changes in employment to a subsequent nursing home.

Department of Health and Human Resources, State-wide trauma/emergency care system, 64 CSR 27

This is an update to an existing rule. The rule pertains to the designation of health care facilities for purposes of trauma and emergency care. The current changes to the rule update the rule to guidelines published by the American College of Surgeons, Committee on Trauma. More particularly, the rule now gives the Commissioner of the Bureau for Public Health great latitude in working with health care facilities to meet the requirements necessary for a trauma designation

Department of Health and Human Resources, Fatality and Mortality Review Team, 64 CSR 29

This is an amendment to an existing rule. Last session this rule was also amended. Those amendments provided for updates to definitions and to the administration of medication which was altered to account for the performance of health maintenance tasks to specifically limit delegation only to those tasks which, after a registered professional nurse makes the appropriate decision, may be properly delegated.

The current changes add definitions that were included in House Bill 4287. These include definitions of family, immediate family, natural supports, pre-filled insulin or insulin pen and primary health care professional. Most substantive are modifications to the definitions of “health maintenance tasks” which now includes administration of pre-filled insulin pens, performing tracheostomy care and ventilator care. These were all permitted under the 2014 statutory change.

The rule also makes modifications to the instruction and training section. These changes are also consistent with the 2014 statutory changes. These include a reorganization of the competency evaluation section and additional retraining requirements.

Finally, the rule was updated to allow orders by a physician or authorized health care professional. Previously, the rule would only allow orders from a physician. There is also a preclusion from performing tracheostomy and ventilator care in specified facilities not authorized by the statute.

CODE REFERENCE: West Virginia Code §64-7-1 et seq. – amended

DATE OF PASSAGE: February 28, 2015

EFFECTIVE DATE: February 28, 2015

ACTION BY GOVERNOR: Signed March 11, 2015

Senate Bill 262

Transferring CHIP and Children's Health Insurance Agency from Department of Administration to DHHR

This bill transfers the Children's Health Insurance Program and Children's Health Insurances Agency from the Department on Administration to the Department of Health and Human Resources. The bill also provides for orderly transfer of functions, funds and accounts, and clarifies the definition of "Children's Health Insurance Agency".

CODE REFERENCE: West Virginia Code §5-16B-1 and §5-16B-2 – amended

DATE OF PASSAGE: February 18, 2015

EFFECTIVE DATE: May 19, 2015

ACTION BY GOVERNOR: Signed March 25, 2015

Senate Bill 267

Repealing code relating to Governor's Office of Health Enhancement and Lifestyle Planning

The bill repeals the Governor's Office of Health Enhancement and Lifestyle Planning, or GOHELP. That Office was created by Code in 2009, and its stated purpose was "to coordinate all state health care system reform initiatives among executive branch agencies, departments, bureaus and offices."

CODE REFERENCE: West Virginia Code §16-29H-1 through §16-29H-10 – repealed

DATE OF PASSAGE: March 13, 2015

EFFECTIVE DATE: June 11, 2015

ACTION BY GOVERNOR: Signed March 24, 2015

Senate Bill 277

Requiring issuance of certificate of birth resulting in stillbirth

This bill would allow either parent of a stillborn child to request a certificate of birth resulting in stillbirth. Under specified circumstances only the mother may request a certificate. There is a provision for a fee which would be the same as a fee for a death certificate. The bill also specifies the information that would need to be included in the certificate.

CODE REFERENCE: West Virginia Code §16-5-20a – new

DATE OF PASSAGE: March 9, 2015

EFFECTIVE DATE: June 7, 2015

ACTION BY GOVERNOR: Signed March 27, 2015

Senate Bill 286

Relating to compulsory immunizations of students; exemptions

This bill rewrites the code sections relative to compulsory immunizations for school children. It sets forth the immunizations that are required for public school attendance in code.

The passed version of the bill codifies the process for obtaining a medical exemption and provides that an exemption would be approved by the State Health Officer who is the Commissioner for the Bureau for Public Health. The Commissioner may appoint an Immunization Specialist who would be a physician who could act as his or her designee in the exemption process.

Finally, the bill alters the make-up of the Immunization Advisory Committee. This committee is to advise the Secretary on the changing needs and opportunities for immunization from known diseases.

CODE REFERENCE: West Virginia Code §16-3-4 and §16-3-5 – amended

DATE OF PASSAGE: March 18, 2015

EFFECTIVE DATE: June 16, 2015

ACTION BY GOVERNOR: Signed March 31, 2015

Senate Bill 295

Establishing appeal process for DHHR Board of Review and Bureau for Medical Services decisions

This bill establishes within the Bureau for Medical Services (BMS) a Board of Review to review grievances of applicants and recipients of state assistance, federal assistance, federal-state assistance and welfare assistance, as well as to providers of Medicaid services.

The bill defines key terms. It requires the Board of Review to provide a “fair, impartial and expeditious grievance and appeal process.” Any party adversely affected or aggrieved by a final decision or order of BMS may seek judicial review. To effectuate the appeal, a copy of the petition must be served upon the agency stating the reason for the appeal. The underlying decision of the agency is not stayed or superseded by the filing of an appeal. Additionally, the agency is required to provide a copy of the entire record to the Circuit Court. The bill identifies what documents are to be included in the record and also includes provisions for the cost of preparing the record. The Circuit Court is permitted to hear issues in the record but may also take additional testimony on issues beyond what is set forth in the record.

The actions which the court may take are set forth in the bill. These include affirming the decision of the Board of Review, remanding the matter for further proceedings or reversing the decision. A reversal requires that the court find that a substantial right of the petitioner was prejudiced because of the BMS decision that violated constitutional or statutory provisions; exceeded the agency’s authority; was made through unlawful procedures; was affected by other error of law; was clearly wrong based up on reliable evidence; was arbitrary and capricious, an abuse of discretion, or an unwarranted exercise of discretion.

The judgement of the Circuit Court is final unless reversed by the Supreme Court.

CODE REFERENCE: West Virginia Code §9-2-13 – new

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

Senate Bill 335

Creating Access to Opioid Antagonists Act

The bill permits emergency responders, state police, sheriffs, deputy sheriffs and volunteer and paid firefighters to carry and administer an opioid antagonist (Naloxone hydrochloride) in an emergency, to respond to instances of opiate overdose.

The bill contains a purpose and objectives section and defines key terms. In addition to first responders, the bill allows prescribers to offer an opioid antagonist to patients to whom they are prescribing an opioid, a relative, friend or caregiver or someone in a position to assist a person at risk. It requires the health care professional to offer information and training to the patient and their family members or caregivers.

The bill provides immunity to licensed health care providers for prescribing and dispensing an opioid antagonist, to initial responders who act in good faith and to any person possessing an opioid antagonist who, acting in good faith, administers it to a person suspected of having an opioid overdose event. It also requires that a person who administers the opioid antagonist to seek additional medical attention for a person suspected of having an opioid overdose.

Additionally, the Office of Emergency Medical Services is required to report certain information to the Legislative Commission on Health and Human Resources Accountability and the Bureau for Behavioral Health and Health Facilities. The bill specifically lists what information is required. The Office is also granted rulemaking authority to develop training requirements for prescribers.

CODE REFERENCE: West Virginia Code §30-1-7a – amended; §16-46-1 through §16-46-6 – new

DATE OF PASSAGE: February 12, 2015 (repassed on February 26, 2015)

EFFECTIVE DATE: May 13, 2015

ACTION BY GOVERNOR: Vetoed February 24, 2015 (technical deficiencies). Corrected and repassed, then signed March 10, 2015.

Senate Bill 336

Eliminating Health Care Authority's power to apply certain penalties to future rate applications

This bill would alter the powers and duties of the Health Care Authority by removing their authority to apply new penalties or penalties held in abeyance to any future rate applications filed with the Authority. It would change the authority of the Health Care Authority to collect from hospitals a financial obligation based upon gross revenue to amount based upon net revenue and would eliminate the authority of the Health Care Authority regarding rate review for hospitals.

CODE REFERENCE: West Virginia Code §16-29B-19 – amended

DATE OF PASSAGE: March 11, 2015

EFFECTIVE DATE: March 11, 2015

ACTION BY GOVERNOR: Signed March 24, 2015

Senate Bill 363

Establishing maximum rates and service limitations for reimbursement of health care services by Court of Claims

This bill allows the Court of Claims to set maximum rates and service limitation reimbursement for health care services rendered by a health care provider for claims before the court. The rates are required to be submitted to the Joint Committee on Government and Finance. There are also provisions that preclude a health care provider from charging any difference between the cost of a service and the court's payment for that service.

CODE REFERENCE: West Virginia Code §14-2A-19b – new

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION BY GOVERNOR: Signed March 31, 2015

Senate Bill 366

Creating Patient Protection and Transparency Act

This bill requires the Insurance Commissioner to post information, or links to information, on its website in a consumer friendly format pertaining to each health care plan offered through the West Virginia Health Benefit Exchange. The exchange is an online portal operated in a partnership between the U.S. Department of Health Human Services and the Office of the Insurance Commissioner which enables citizens to enroll in health insurance under the ACA. The information required to be made available is related to names and types of providers in the network; information about exclusions or restrictions in the plans; information on coinsurance, copayments and cost sharing under the plans; information pertaining to prescription coverage under the plans; information about appealing plan decisions; and contact information for the carrier.

CODE REFERENCE: West Virginia Code §33-50-1, §33-50-2 and §33-50-3 – new

DATE OF PASSAGE: March 11, 2015

EFFECTIVE DATE: June 9, 2015

ACTION BY GOVERNOR: Signed March 18, 2015

Senate Bill 398

Extending expiration date for health care provider tax on eligible acute care hospitals

This bill would modify the expiration date of an upper payment limit in the state Medicaid program which allowed an additional provider taxes on eligible acute care hospitals for maximizing federal Medicaid funds. The current expiration date of June 30, 2015, would be changed to June 30, 2016. Additionally, it modifies the tax rate from the current 62/100's of one percent to 72/100's of one percent.

Current code defines what facilities are eligible. It specifically excludes state owed facilities and nonstate, but government owned facilities, critical access hospitals, licensed free-standing psychiatric or medical rehabilitation hospitals or long-term acute care hospitals.

The law provided for events that must occur prior to the imposition of the tax. These included the development of a state plan amendment, approval of the state plan amendment and a thirty day comment period. The bill also sets forth information that is required to be submitted in the state plan amendment. A special revenue account is created within the state treasury to be known as the Medicaid State Share Fund for deposits and payments to meet the provisions of the section. All of these contingencies and requirements have been met. The law also contains a list of events that would immediately suspend the collection of the tax.

CODE REFERENCE: West Virginia Code §11-27-38 – amended

DATE OF PASSAGE: February 27, 2015

EFFECTIVE DATE: July 1, 2015

ACTION BY GOVERNOR: Signed on March 6, 2015

Senate Bill 425

Relating to investments by MU, WVU and WVSOM

This bill removes the cap on the amount of institutional funds that West Virginia University (WVU), Marshall University (MU) and West Virginia School of Osteopathic Medicine (WVSOM) may invest with their respective non-profit foundations. The institutions are prohibited from investing moneys derived from the state General Revenue Fund or Excess Lottery Fund.

Foundation investments produce a higher rate of return than the state's Consolidated Investment Fund, but are still required to comply with the Uniform Prudent Investor Act (UPIA). Each governing board must establish an investment policy in compliance with the UPIA and report annually by December 31st to the Governor and the Joint Committee on Government and Finance regarding performance of the investments.

CODE REFERENCE: West Virginia Code §12-1-12d – amended

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION OF GOVERNOR: Signed March 31, 2015

Senate Bill 523

Creating Alcohol and Drug Overdose Prevention and Clemency Act

This bill permits immunity from citation, arrest or prosecution for certain offenses for persons who seek appropriate medical treatment either for themselves or others in instances of drug or alcohol overdose. A person may not be cited for the following offenses:

- Purchasing, consuming or possessing wine, beer, liquor or alcohol by someone under age 21;
- Ordering, paying for, sharing the cost of, purchasing, consuming or possessing beer, wine, liquor or alcohol;
- Purchasing nonintoxicating beer, wine, liquor or alcohol from a licensee through misrepresentation of age;
- Simple possession of a controlled substance or imitation controlled substance without a prescription;
- Appearing in a public place intoxicated or giving someone a drink in a public place.

The bill expressly provides selling or serving wine, alcohol, beer, or liquor by someone under the age of 21 is not eligible for immunity.

The person who seeks medical treatment shall provide certain information and cooperate with law enforcement and medical assistance personnel. A person convicted on other charges, not provided for in this article, because of his or her actions under this article, may receive mitigating circumstances at sentencing. Immunity extends to the person for whom medical assistance is sought, subsequent to receiving medical assistance, if that person complies and completes a secular or faith based substance abuse treatment/recovery program approved by the prosecutor. The bill requires that a person acting under the provisions of this bill receive consideration for alternative sentencing.

CODE REFERENCE: West Virginia Code §16-47-1 through §16-47-6 – new

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION BY GOVERNOR: Signed April 2, 2015

Senate Bill 532

Relating to civil liability immunity for clinical practice plans and medical and dental school personnel

This bill requires that the West Virginia Board of Risk and Insurance Management provide medical professional liability insurance to the state's medical and dental schools, including all of their clinical practice plans, all of their directors, officers, employees and agents.

CODE REFERENCE: West Virginia Code §55-7E-1 through §55-7E-6 – new

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 24, 2015

Senate Bill 578

Relating to occupational disease claims

Under current law, the claimant, the employer and the Workers' Compensation Commission, other private insurance carriers and self-insured employers, whichever is applicable, may negotiate a final settlement of any and all issues in a claim, wherever the worker's compensation claim is in the administrative or appellate processes, except for medical benefits for nonorthopedic occupational disease claims. This bill removes the exception for settlements of medical benefits for nonorthopedic occupational disease claims, which would permit the negotiation of final settlements of all components of worker's compensation claims, permitting settlements of medical benefits for nonorthopedic occupational disease claims, including settlements of occupational pneumoconiosis claims. The bill requires that a claimant in a settlement of medical benefits for a nonorthopedic occupational disease claims be represented by legal counsel.

The bill specifies that the amendments enacted during the current 2015 regular session of the Legislature apply to all settlement agreements executed after the effective date of the legislation.

CODE REFERENCE: West Virginia Code §23-4-8d – amended

DATE OF PASSAGE: March 10, 2015

EFFECTIVE DATE: June 8, 2015

ACTION BY GOVERNOR: Signed March 24, 2015

Senate Bill 583

Increasing tax rate on providers of certain nursing facility services.

The bill changes the health care provider tax rate on providers of certain nursing facility services from 5.5% of gross receipts to 5.72% between October 1, 2015 and June 30, 2016. The tax rate then goes back to 5.5% beginning July 1, 2016. The rate increase is an effort to address increased state funding for the Medicaid program in the 2016 fiscal year. The beginning date of October 1, 2015, affords the State Tax Division time to update software and returns that would be required for the rate change.

CODE REFERENCE: West Virginia Code §11-27-11 – amended

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: July 1, 2015

ACTION OF GOVERNOR: Signed March 26, 2015

House Bill 2098

Authorizing those health care professionals to provide services to patients or residents of state run veterans' facilities without obtaining an authorization to practice

This bill allows the Board of Medicine or the Board of Osteopathy to issue a license to a physician practicing in a Federal Veteran's Administration Hospital without an exam if the Federal Veteran's Administration Hospital is located in a county in which a nursing home is operated by the W. Va. Department of Veteran's Assistance. The license is limited to practice in the nursing home. No fee may be charged.

The boards are required to promulgate emergency rules to implement the provisions of the article and to report back to the Legislative Oversight Commission on Health and Human Resources Accountability by 7/1/16.

CODE REFERENCE: West Virginia Code §30-3-11b and §30-14-12c – new

DATE OF PASSAGE: March 13, 2015

EFFECTIVE DATE: June 11, 2015

ACTION BY GOVERNOR: Signed March 25, 2015

House Bill 2100

Caregiver Advise, Record and Enable Act

This bill would allow a person being discharged from a hospital to designate a lay caregiver to provide after-care needs.

The bill defines terms. It sets forth the means for designation of a caregiver by the patient or his or her legal guardian. The bill further provides for the hospital to notify the caregiver upon discharge and to consult with the caregiver and the patient regarding the needed care. There are provisions for a consent to receive the medical records of the patient and for instruction and of the care needed.

Finally, the bill states that the article may not be seen as interfering with the rights of a person to make health care decisions and grants a limitation of liability to the hospital, its employees or agents. It also precludes the spending of state or federal funds to pay a lay caregiver for the services.

CODE REFERENCE: West Virginia Code §16-5X-1 through §16-5X-6 – new

DATE OF PASSAGE: March 10, 2015

EFFECTIVE DATE: June 8, 2015

ACTION BY GOVERNOR: Signed March 27, 2015

House Bill 2272

Relating to the authority of the Board of Pharmacy

This bill updates the Board of Pharmacy's rule-making authority. It repeals the board's authority to develop an official prescription paper program and permits the board to develop an electronic official prescription program.

The bill also clarifies that pharmacy interns may administer immunizations for Hepatitis A and B, Herpes Zoster and Tetanus.

CODE REFERENCE: West Virginia Code §16-5W-1 through §16-5W-8 – repealed; §30-5-7 – amended

DATE OF PASSAGE: March 9, 2015

EFFECTIVE DATE: June 7, 2015

ACTION BY GOVERNOR: Signed March 27, 2015

House Bill 2432

Relating to the licensure requirements to practice pharmacist care

This bill prohibits the board from issuing a license for pharmacist care to a person convicted of a felony involving the sale or distribution of controlled substances. The bill also permits the board to reinstate an applicant with any other felony conviction, other than the conviction for the sale or distribution of controlled substances, no sooner than five years after the date of the conviction.

CODE REFERENCE: West Virginia Code §30-5-9 – amended

DATE OF PASSAGE: March 9, 2015

EFFECTIVE DATE: June 7, 2015

ACTION BY GOVERNOR: Signed March 27, 2015

House Bill 2493

Relating to requirements for insurance policies and contracts providing accident and sickness insurance or direct health care services that cover anti cancer medications

This bill requires insurance policies to cover the cost of orally administered or self-injected anti-cancer medications in the same manner as injected or intravenously administered anti-cancer medications. The bill prohibits insurance policies and contracts providing accident and sickness insurance or direct health care services that cover anti-cancer medications from charging higher copayments, deductibles or coinsurance for orally or self administered anti-cancer medications than is required for anti-cancer medications administered by injection or intravenously.

The bill prohibits policies and contracts for health benefits from complying with these new sections by:

- Increasing the copayment amount for injected or intravenously administered anticancer medications; or
- Reclassifying benefits with respect to anti-cancer medications.

The requirements apply to policies or contracts that are issued or renewed after January 1, 2016.

The bill also allows for cost containment measures by the insurer or if the cost of compliance exceeds two per cent of the total cost of coverage.

These provisions are applicable to accident and sickness insurance (§33-15-41), group accident and sickness insurance (§33-16-3x), hospital service corporations, medical service corporations, dental service corporations and health service corporations (§33-24-7m), health care corporations (§33-25-8j), and HMO's (§ 33-25-A-81).

CODE REFERENCE: West Virginia Code §33-15-41, §33-16-3x, §33-24-7m, §33-25-8j, and § 33-25A-81 – new

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 25, 2015

House Bill 2496

Adopting the Interstate Medical Licensure Compact

The practice of medicine in the 21st century involves technical advances in the area of tele-health technology and practice, such as “tele-medicine” which, for example, permits a radiologist to timely read and interpret radiological studies from great physical distance.

The Compact is expected to significantly reduce barriers to the process of gaining licensure in multiple states at a time when tele-medicine is growing and millions of new patients are likely to enter into the U.S. health care system.

In April 2013 the Federation of State Medical Boards (FSMB) unanimously endorsed development of an interstate compact to expedite medical licensure and facilitate multi state practice. FSMB convened representatives from state medical boards and special experts to explore the formation of an Interstate Compact to enhance license portability.

A team of state medical board representatives and experts from the Council of State Governments (CSG) developed and drafted a framework for an Interstate Medical Licensure Compact — a new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact.

Medical board representatives from a diverse collection of states, in terms of population, size, and geographic region, worked in conjunction with compact experts from CSG and FSMB staff to define eight component principles that guide the compact:

- Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
- Participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state’s existing Medical Practice Act.
- The practice of medicine occurs where the patient is located at the time of the physician patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
- An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice occurs.
- Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that would administer a compact.
- A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state wherein he / she chooses to practice.
- State boards participating in an interstate compact are required to share complaint / investigative information with each other.
- The license to practice can be revoked by any or all of the compact states.

Model legislation — Interstate Medical Licensure Compact is now pending in fourteen (14) state legislature, including West Virginia. South Dakota, Utah, and Wyoming – have already passed the Interstate Medical Licensure Compact. Participation in the Compact would be voluntary, for both states and physicians. Seven states must pass the compact for it take effect.

Endorsements include a bipartisan group of 16 U.S. Senators who have publicly commended the FSMB for its efforts, including former Senator Rockefeller.

CODE REFERENCE: West Virginia Code §30-1C-1 through §30-1C-24 – new

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 31, 2015



House Bill 2535

Relating generally to suicide prevention training

The purpose of this bill is to increase suicide prevention awareness. The bill requires public middle school and high school administrators to disseminate and provide opportunities to discuss suicide prevention awareness information with students.

The bill also requires each college and university to develop and implement a policy to advise students and staff on suicide prevention programs available on and off campus. The policy shall be posted on its website.

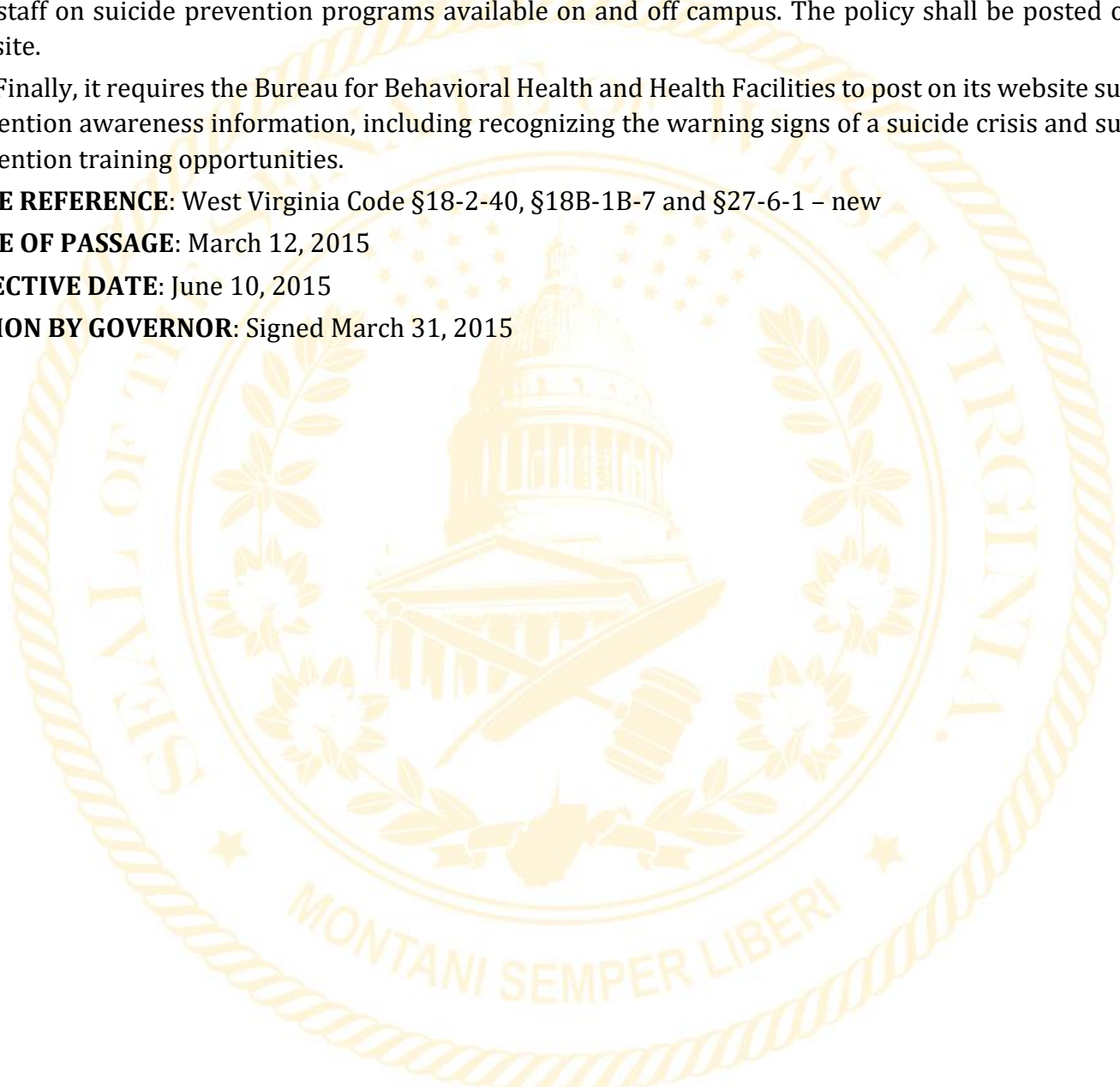
Finally, it requires the Bureau for Behavioral Health and Health Facilities to post on its website suicide prevention awareness information, including recognizing the warning signs of a suicide crisis and suicide prevention training opportunities.

CODE REFERENCE: West Virginia Code §18-2-40, §18B-1B-7 and §27-6-1 – new

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 31, 2015



House Bill 2568

The Pain-Capable Unborn Child Protection Act

This bill prohibits abortions in most instances after the twentieth week after conception, or twenty-two weeks after the first day of the mother's last menstrual cycle. The bill makes legislative findings and definitions, provides for exceptions to that prohibition, sets forth a reporting requirement for medical providers and establishes penalties for failing to comply with the provisions of the article.

The first section, §16-2M-1, sets forth a number of legislative findings that directly address the ability of the fetus or unborn child to feel and respond to painful stimuli. This section also asserts "a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that they are capable of feeling pain."

§16-2M-2 defines a number of terms used throughout the article.

§16-2M-3 requires, in most instances, that a physician performing an abortion must determine the probable gestational age of the fetus or unborn child before performing the abortion. Such a determination is not required when a medical emergency exists, the fetus is non-viable, or the determination of gestational age has been made by another doctor and that determination is relied upon by the performing doctor.

The next section, §16-2M-4, prohibits any person from performing or inducing, or attempting to perform or induce, an abortion of a fetus once it has reached pain-capable gestational age. Certain exemptions are provided, including cases in which the fetus is determined to be non-viable or when the pregnancy complicates the mother's physical health and medical condition such that an abortion is necessary "to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions." This section also requires that, when a fetus or unborn child is aborted after it has reached pain capable age, that the abortion will be conducted in a manner that "in reasonable medical judgment, provides the best opportunity for the fetus to survive," with certain exceptions.

Physicians who perform an abortion are required, pursuant to §16-2M-5, to make reports to the Bureau for Public Health, with certain information about the abortion, including:

- probable gestational age
- the manner in which the age was determined
- if no gestational age was determined, the reason for not doing so
- the method of abortion
- the basis for determining that the fetus was non-viable or there was a medical condition that necessitated an abortion after pain capable age
- whether the method of abortion used was the one that provided the best opportunity for the fetus to survive, and,
- if not, the basis of the determination that doing so would place the mother at substantial risk.

Additional language protects the privacy of the patient. The information collected from these reports is to be compiled by DHHR and issued annually beginning June 30, 2016.

§16-2M-6 delineates penalties for violations of this article. For physicians and licensed medical practitioners, violating the article would be treated as acting outside the scope of practice, making them subject to discipline from the applicable licensure board. For non-licensed medical practitioners, violations of this article would be considered the unauthorized practice of medicine, which would be a misdemeanor.

The penalties for that unauthorized practice could a \$5,000 fine and/or up to twelve months in jail. The bill does not limit available remedies by a patient, and further ensures that the patient herself is not subject to any penalties or criminal sanctions.

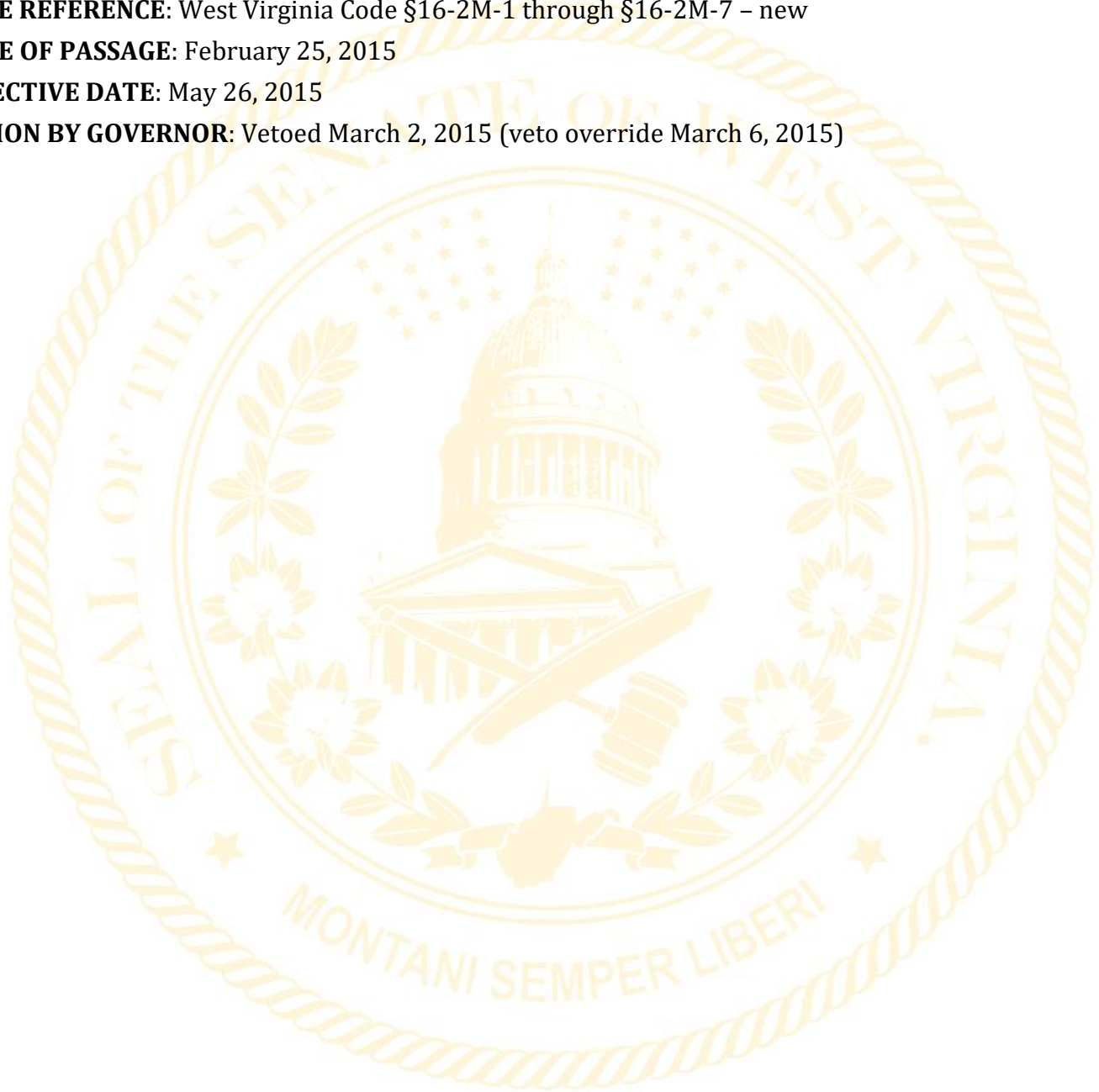
Finally, §16-2M-7 provides explicitly for severability of any portion of the article that is “found to be unconstitutional or temporarily or permanently restrained or enjoined by judicial order, or both,” and to allow for the remainder of the article to remain in effect.

CODE REFERENCE: West Virginia Code §16-2M-1 through §16-2M-7 – new

DATE OF PASSAGE: February 25, 2015

EFFECTIVE DATE: May 26, 2015

ACTION BY GOVERNOR: Vetoed March 2, 2015 (veto override March 6, 2015)



House Bill 2595

Relating to certificates of need for the development of health facilities in this state

This bill would clarify that an entity considered to be an “affected person” for purposes of filings for a Certificate of Need must be located within the state of West Virginia.

CODE REFERENCE: West Virginia Code §16-2D-2 and §16-2D-6 – amended

DATE OF PASSAGE: March 14, 2015

EFFECTIVE DATE: June 12, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

House Bill 2648

Allowing authorized entities to maintain a stock of epinephrine auto-injectors to be used for emergency

This bill creates a new article titled Epinephrine Auto-Injector Availability and Usage. It defines terms, authorizes the Department of Health and Human Resources to propose rules for promulgation, requires that educational programs be conducted by a nationally recognized organization experienced in training lay persons or an entity approved by the Department, sets minimum curriculum and provides for the prescribing and dispensing of epinephrine auto injectors to authorized entities. An authorized entity is required to designate trained persons to be responsible for the storage, maintenance and general oversight of the auto injectors. A trained individual may provide an auto injector to a person he or she believes in good faith is experiencing a severe allergic reaction for self-administration or the individual may administer the injection. This bill also states the administration of an epinephrine auto-injector is not the practice of medicine. It states the prescribing physician, the authorized entity, the person who conducted the training and the trained person who administered the injection are not subject to civil liability.

CODE REFERENCE: West Virginia Code §16-47-1 through §16-47-5 – new

DATE OF PASSAGE: March 18, 2015

EFFECTIVE DATE: June 16, 2015

ACTION BY GOVERNOR: Signed April 2, 2015

House Bill 2652

Reducing the assessment paid by hospitals to the Health Care Authority

This bill modifies the formula for the assessment currently paid by hospitals to the Health Care Authority. Currently, the formula is based on gross revenues, it is changed to net patient revenue. The effect of the change is a reduction of the assessment and a decrease in special revenue dedicated to the operations of the Health Care Authority.

CODE REFERENCE: West Virginia Code §16-29B-8 – amended

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 27, 2015

House Bill 2662

Eye Care Consumer Protection Law

This bill creates the Eye Care Consumer Protection Law. It prohibits prescriptions to be determined or performed by any means other than by a licensee, or a person under the direct supervision of a licensee, who is physically present during the determinations is taking place. It further prohibits the dispensing of spectacles or contact lens without a valid prescription and the use of an automated refractor or device which generates refractive data unless used under the direct supervision of a licensee.

CODE REFERENCE: West Virginia Code §30-8A-1 through §30-8A-5 – new

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

House Bill 2669

Relating to compulsory tuberculosis testing

This bill would alter the requirements for administration of a tuberculin test for school. Currently all students transferring into the schools of this state be required to take a tuberculin test within four months of entry. The Center for Disease Control has now recommended that this is no longer necessary. This bill would adopt their suggestion and only test pupils and school personnel who are suspected to have active tuberculosis. The bill also amends the definition section for consistency.

CODE REFERENCE: West Virginia Code §16-3D-2 and §16-3D-3 – amended

DATE OF PASSAGE: February 25, 2015

EFFECTIVE DATE: May 26, 2015

ACTION BY GOVERNOR: Signed March 3, 2015

House Bill 2733

Removing certain combinations of drugs containing hydrocodone from Schedule III of the controlled substances law

The purpose of this bill is to remove certain drugs from Schedule III of the controlled substances law. The bill also updates the requirements of the Control Substance Monitoring Program. It clarifies the information that is required when picking up someone else's prescription and eliminates the specified training program for those person who may access the database and allows the Board to approve a training program. The bill would also extend the expiration date of law relating to the Multi State Real Time Tracking System through June 30, 2017.

CODE REFERENCE: West Virginia Code §60A-2-208, §60A-9-3, §60A-9-4, §60A-9-5, and §60-A-10-16 – amended

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

House Bill 2776

Relating to prescribing hydrocodone combination drugs for a duration of no more than three days

This bill allows physician assistants, advance practice registered nurses and optometrists to prescribe hydrocodone combination drugs for a 72-hour period.

CODE REFERENCE: West Virginia Code §30-3E-12, §30-7-15a and §30-8-9 – amended

DATE OF PASSAGE: March 9, 2015

EFFECTIVE DATE: June 7, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

House Bill 2811

Deleting obsolete provisions regarding the Physicians' Mutual Insurance Company

This bill deletes obsolete provisions in the West Virginia Code regarding the Physician's Mutual Insurance Company, and also provides that the company need not be organized as a nonprofit corporation provided that the company remain a domestic mutual insurance company owned by its policyholders.

CODE REFERENCE: West Virginia Code §33-20F-4 – amended

DATE OF PASSAGE: March 13, 2015

EFFECTIVE DATE: June 11, 2015

ACTION BY GOVERNOR: Signed April 1, 2015

House Bill 2880

Creating an addiction treatment pilot program

This bill allowed oversight of a pilot program by the West Virginia Department of Health and Human Resources to allow drug courts and the Division of Corrections to provide addiction treatment to specified offenders.

The bill defines key terms. It provides for medication assisted treatment of an FDA approved drug that is long acting and is used in conjunction with psychosocial support. The program would be done through drug courts or the work release program at the Division of Corrections.

Following enactment, the bill required the selection of a research partner to provide an assessment of the program. They are required to submit a report to various entities which are set out in the bill.

CODE REFERENCE: West Virginia Code §62-15A-1 through §62-15A-3 – new

DATE OF PASSAGE: March 18, 2015

EFFECTIVE DATE: June 16, 2015

ACTION BY GOVERNOR: Signed March 31, 2015

House Bill 2931

Adding drugs to the classification of schedule I drugs

This bill would alter those substances listed under Schedule I for Controlled Substance. It adds three substances to hallucinogenic drugs their salts, isomers and salts of isomers. Additionally, it adds to the list tryptamines. There are eleven substances listed under that heading. These hallucinogens produce muscle relaxation, dilation of pupils, vivid visual and auditory distortions, and emotional disturbances. Finally, the bill adds ten substituted amphetamines to the list. These are psychoactive chemicals used as stimulants.

CODE REFERENCE: West Virginia Code §60A-2-204 – amended

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: June 10, 2015

ACTION BY GOVERNOR: Signed March 2, 2015

House Bill 2976

Expanding the eligible master's and doctoral level programs for which a Nursing Scholarship may be awarded

This bill broadens the Nursing Scholarship Program's eligibility criteria to include appropriate degree programs through which the nurse educator shortage can be addressed. The Nursing Scholarship Program provides awards targeted toward individuals who will help fill the nursing and nurse educator shortages in WV. Masters level students pursuing any type of nursing degree would now qualify for a scholarship. Currently only students enrolled in a nurse educator master's degree program are eligible for a masters level award. Eligibility for a doctoral level award is expanded to include students enrolled in a doctoral level education program. Scholarship recipients at the masters and doctoral levels are required to teach nursing in the state for two years following graduation.

CODE REFERENCE: West Virginia Code §18C-3-4 – amended

DATE OF PASSAGE: March 12, 2015

EFFECTIVE DATE: March 12, 2015

ACTION OF GOVERNOR: Signed March 27, 2015

House Bill 2999

Relating to neonatal abstinence centers

This bill allow for the creation of neonatal abstinence centers in skilled nursing centers. It would exempt these facilities from Certificate of Need. It sets forth the type of services that may be offered by such facilities and requires the Secretary of DHHR to develop licensing requirements.

CODE REFERENCE: West Virginia Code §16-2D-5 – amended; §16-2D-5f, and §16-2M-1 through §16-2M-3 – new

DATE OF PASSAGE: March 9, 2015

EFFECTIVE DATE: June 7, 2017

ACTION BY GOVERNOR: Signed April 2, 2015